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103D CONGRESS
1ST SESSION

H. R. 1398

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 1993

Mr. CARDIN introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, and Education and Labor

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A BILL

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Flexible Medical Access and Cost Containment Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—REQUIRING EMPLOYERS TO PROVIDE HEALTH INSURANCE COVERAGE FOR EMPLOYEES AND DEPENDENTS

Sec. 101. Requirement.
Sec. 102. Meeting requirement through enrollment of employees and families under qualified employer health plans.

''TITLE XXI—REQUIREMENT FOR ENROLLMENT OF EMPLOYEES UNDER A QUALIFIED EMPLOYER HEALTH PLAN

''Sec. 2100. Relation to Internal Revenue Code requirement.

''PART A—EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES IN A QUALIFIED EMPLOYER HEALTH PLAN

''Sec. 2101. Application to full-time employees.
''Sec. 2102. Application to part-time employees.
''Sec. 2103. Application to seasonal and temporary employees.
''Sec. 2104. Treatment of all family members as a unit; uniform treatment of full-time employees and of part-time employees.
''Sec. 2105. Application of requirement to employers of different sizes.
''Sec. 2106. Timing of enrollment; period of coverage.

''PART B—REQUIREMENTS FOR QUALIFIED EMPLOYER HEALTH PLANS

''Sec. 2121. Qualified employer health plan defined.
''Sec. 2122. Requirements relating to employee premiums and cost-sharing.

''PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

''Sec. 2151. Certification of qualified health plans.
''Sec. 2152. Treatment of family as a unit; coverage period; health plan cards.
''Sec. 2153. Requirements respecting basic benefits.
''Sec. 2154. Requirements respecting limits on pre-existing condition exclusions and coverage standards for basic health services.
''Sec. 2155. Requirements respecting limits on cost-sharing.
''Sec. 2156. Use of payment rates.
''Sec. 2157. Coordination and portability of health coverage under qualified health plans.
''Sec. 2158. Consumer protections.
''Sec. 2159. Preemption of certain state and federal requirements.
''Sec. 2160. Use of uniform claims forms; uniform information reporting.

''PART D—DEFINITIONS AND MISCELLANEOUS

''Sec. 2181. Definitions.
''Sec. 2182. Nonapplication to residents of Puerto Rico and territories.
Sec. 103. Repeal of COBRA continuation requirements.

TITLE II—PROVISION OF HEALTH INSURANCE THROUGH A PUBLIC HEALTH PLAN

Sec. 201. Public health plan.

''TITLE XXII—PUBLIC HEALTH PLAN

''PART A—ELIGIBILITY AND ENROLLMENT

''Sec. 2201. Eligibility to enroll for health insurance benefits and to apply for low-income assistance.
''Sec. 2202. Application for enrollment.
''Sec. 2203. Coverage period; termination of enrollment.
''Sec. 2204. Requirement of health insurance coverage.

''PART B—HEALTH INSURANCE BENEFITS

''Sec. 2211. Required health services.

''PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLES, COINSURANCE, AND STOP-LOSS PROTECTION FOR REQUIRED HEALTH SERVICES

''Sec. 2221. Payments for benefits.
''Sec. 2222. Deductible for required health services.
''Sec. 2223. Coinsurance for required health services.
''Sec. 2224. Limit on cost-sharing for required health services.
''Sec. 2225. Exclusions; coordination.
''Sec. 2226. Application of particular qualified health plan requirements.

''PART D—PREMIUMS, PUBLIC HEALTH TRUST FUND

''Sec. 2231. Premiums.
''Sec. 2232. Collection of premiums.
''Sec. 2233. Public Health Trust Fund.
''Sec. 2234. Transfer payments in the case of multiple employers.
''Sec. 2235. Use of uniform claims forms; uniform information reporting.

''PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

''Sec. 2241. Assistance for individuals with income below the poverty line enrolled on a non-employment basis.
''Sec. 2242. Assistance for individuals with income below twice the poverty line enrolled on a non-employment basis.
''Sec. 2243. Assistance for individuals covered under qualified employer health plans.
''Sec. 2244. Applications for assistance.
''Sec. 2245. Reconciliation of premium assistance through use of income statements.
''Sec. 2246. Treatment of certain cash assistance recipients.
''Sec. 2247. Computation of family adjusted total income.

''PART F—ADMINISTRATIVE PROVISIONS

''Sec. 2261. Agreements with hospitals; participating physicians; treatment of Indian Health Service facilities.
''Sec. 2262. Health maintenance organizations.
''Sec. 2263. Use of fiscal agents.
''Sec. 2264. General administration.
''Sec. 2265. Determinations; appeals; Provider Reimbursement Review Board.
''Sec. 2266. Program integrity; miscellaneous provisions.
''Sec. 2267. Information by telephone.
''Sec. 2268. Demonstration project authority.

''Sec. 2269. Incorporation of miscellaneous medicare provisions.

''PART G—[RESERVED]

''PART H—DEFINITIONS AND MISCELLANEOUS

''Sec. 2281. Incorporation of certain definitions used in other health-related titles.
''Sec. 2282. Definitions relating to families.
''Sec. 2283. Other definitions.
''Sec. 2284. Authorizing reciprocal coverage of foreign nationals.
''Sec. 2285. Nonapplication to residents of Puerto Rico and territories.

TITLE III—COST CONTAINMENT

Subtitle A—Health Care Spending Amounts

Sec. 301. Specification of overall health care spending amounts.
Sec. 302. Establishment of Federal Health Care Cost Containment Commission.
Sec. 303. State Health Rate Commissions.
Sec. 304. Standard for payment rates.
Sec. 305. Application of rates under medicare and public programs.

Subtitle B—Administrative Simplification

Sec. 321. Requirement for uniform health claims cards.
Sec. 322. Requirement for entitlement verification system.
Sec. 323. Requirements for uniform claims and electronic claims data set.
Sec. 324. Electronic medical records and reporting.
Sec. 325. Uniform hospital cost reporting.
Sec. 326. Definitions.

Subtitle C—Malpractice Reform

Sec. 331. Malpractice reform.

TITLE IV—GROUP HEALTH INSURANCE REFORM

Sec. 401. Excise tax on premiums received on health insurance policies which do not meet certain requirements.
Sec. 402. Group health insurance standards.

''TITLE XXIII—GROUP HEALTH INSURANCE STANDARDS

''PART 1—GENERAL STANDARDS; DEFINITIONS

''Sec. 2301. Application of requirements to employment-related health plans.
''Sec. 2302. Establishment of standards.
''Sec. 2303. Requirements applicable to all employment-related health plans.
''Sec. 2304. Definitions.
''Sec. 2305. Notice of plans meetings requirements.

''PART 2—SMALL EMPLOYER HEALTH INSURANCE REFORM

''Sec. 2311. Enrollment practice and guaranteed renewability requirements for small employer health plans.

''Sec. 2312. Rating practices for small employer health plans.
''Sec. 2313. Basic benefit package for small employer health plans.
''Sec. 2314. Miscellaneous disclosure and record-keeping requirements for small employer health plans.
''Sec. 2315. Payment of commissions.
''Sec. 2316. Nonapplication in Puerto Rico and the territories.

TITLE V—CHANGES IN MEDICARE PROGRAM

Sec. 501. Coverage of colorectal screening.
Sec. 502. Coverage of certain immunizations.
Sec. 503. Coverage of well-child care.
Sec. 504. Annual screening mammography.
Sec. 505. Demonstration projects for coverage of other preventive services.
Sec. 506. OTA study of process for review of medicare coverage of preventive services.
Sec. 507. Phased-in requirement of part B enrollment.
Sec. 508. Changes in participation agreements.
Sec. 509. Assuring coordination of enrollment with qualified health plans.

TITLE VI—FINANCING PROVISIONS

Subtitle A—General Provisions

Sec. 601. Increase in wage base for hospital insurance tax.

Subtitle B—Deductibility of Certain Health Insurance Costs

Sec. 611. Indefinite extension of deduction for health insurance costs of self-employed individuals.
Sec. 612. Increase in amount of deduction for self-employed individuals.
Sec. 613. Deduction for premiums paid by small employers for insurance providing qualified health coverage.

Subtitle C—State Maintenance of Effort

Sec. 621. State maintenance of effort.

TITLE VII—MEDICAID PROVISIONS

Sec. 701. Coordination with public health plan.

TITLE I—REQUIRING EMPLOYERS TO PROVIDE HEALTH INSURANCE COVERAGE FOR EMPLOYEES AND DEPENDENTS

SEC. 101. REQUIREMENT.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new section:

"SEC. 5000A. FAILURE TO COVER EMPLOYEES AND DEPENDENTS UNDER A QUALIFIED EMPLOYER HEALTH PLAN.

''(a) IMPOSITION OF TAX.—In addition to other taxes, if an employee of any employer is not covered under a qualified employer health plan of such employer, there is hereby imposed on such employer a tax.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to an employee shall be $100 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(c) LIABILITY FOR TAX.—The employer shall be liable for the tax imposed by subsection (a).

''(d) EXCEPTIONS.—

''(1) TRANSITION.—The taxes imposed by this section shall not take effect before the date on which the requirements of part A of title XXI of the Social Security Act apply with respect to the employer under section 2105(a) of such Act.

''(2) EMPLOYEES COVERED BY FEDERAL HEALTH PLAN.—The taxes imposed by this section shall not apply to any employee of the United States if, by reason of such employment (or the employment of a family member), the employee—

''(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

''(B) is provided medical and dental benefits under chapter 55 of title 10 of such Code.

''(3) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a)

on any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(4) TAX NOT TO APPLY TO FAILURE CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the first 30 days of the noncompliance period with respect to such failure.

''(5) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part of all of the tax imposed by subsection (a) to the extent that the payment of such tax would be unduly burdensome relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE; EMPLOYER.—The terms 'employee' and 'employer' have the same meanings as such terms have for purposes of chapter 21.

''(2) QUALIFIED EMPLOYER HEALTH PLAN.—The term 'qualified employer health plan' means a

plan meeting the requirements of title XXI of the Social Security Act.

''(3) COVERED.—An employee is not considered to be 'covered' under a qualified employer health plan if a dependent of the employee, whose coverage is provided for under title XXI of the Social Security Act, is not covered under such plan.''.

(b) DEFICIENCY PROCEDURES TO APPLY TO CHAPTER 47.—

(1) The following provisions of the Internal Revenue Code of 1986 are each amended by striking ''or 44'' each place it appears and inserting ''44, or 47''.

(A) Subsections (a) and (b)(2) of section 6211.

(B) Section 6212(a).

(C) Subsections (a) and (g) of section 6213.

(D) Subsections (c) and (d) of section 6214.

(E) Section 6161(b)(1).

(F) Section 6344(a)(1).

(G) Subsections (a) and (b)(1) of section 6512.

(H) Section 7422(e).

(2) Sections 6211(a) and 6862(a) of such Code are each amended by striking ''and 44'' and inserting ''44, and 47''.

(3) Paragraph (1) of section 6212(b) of such Code is amended—

(A) by striking ''or chapter 44'' and inserting ''chapter 44, or chapter 47'', and

(B) by striking ''chapter 44, and this chapter'' and inserting ''chapter 44, chapter 47, and this chapter''.

(4) Paragraph (1) of section 6212(c) of such Code is amended by striking ''or of chapter 44 tax for the same taxable period'' and inserting '', of chapter 44 tax for the same taxable period, or of chapter 47 for each act or failure to act to which the petition relates''.

(c) CLERICAL AMENDMENTS.—

(1) So much of chapter 47 of such Code as precedes subsection (a) of section 5000 is amended to read as follows:

''CHAPTER 47—TAXES RELATING TO GROUP HEALTH PLANS

''Sec. 5000. Contributions to nonconforming large group health plans.
''Sec. 5000A. Failure to cover employees and dependents under a qualified employer health plan.

"SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE GROUP HEALTH PLANS."

(2) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 47 and inserting the following:

''Chapter 47. Taxes relating to group health plans.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to failures occurring after December 31, 1993.

SEC. 102. MEETING REQUIREMENT THROUGH ENROLLMENT OF EMPLOYEES AND FAMILIES UNDER QUALIFIED EMPLOYER HEALTH PLANS.

The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—REQUIREMENT FOR ENROLLMENT OF EMPLOYEES UNDER A QUALIFIED EMPLOYER HEALTH PLAN

"SEC. 2100. RELATION TO INTERNAL REVENUE CODE REQUIREMENT.

''(a) IN GENERAL.—If an employer fails to enroll employees (and family members) under a qualified employer health plan in accordance with this title, the employer is liable for payment of an excise tax under section 5000A(a) of the Internal Revenue Code of 1986.

''(b) TREATMENT OF SMALL EMPLOYERS.—A small employer may meet such requirements through purchase

of coverage under the public plan provided under title XXII.

''PART A—EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES IN A QUALIFIED EMPLOYER HEALTH PLAN

"SEC. 2101. APPLICATION TO FULL-TIME EMPLOYEES.

''(a) UNMARRIED EMPLOYEES.—

''(1) IN GENERAL.—Except as provided in this part, each employer shall, in accordance with this title, enroll each of its full-time employees who is unmarried in a qualified employer health plan.

''(2) MULTIPLE FULL-TIME EMPLOYMENT.—

''(A) EACH OFFERS QUALIFIED PLAN.—In the case of an unmarried individual who is a full-time employee of more than 1 employer, if more than 1 such employer offers the employee enrollment under a qualified employer health plan—

''(i) the individual shall elect (in a manner specified by the Secretary) the qualified employer health plan under which the individual (and family members) will be enrolled;

''(ii) a nonenrolling employer—

''(I) is not obligated to enroll the employee (and family members) under its qualified employer health plan (if any) and may not charge the individual any premiums for required coverage under the qualified employer health plan, and

''(II) is not liable for any tax under section 3151(a)(1) of the Internal Revenue Code of 1986 but is liable for a nonenrolling employer premium under section 2234(a)(1)(A); and

''(iii) the enrolling employer is eligible for an enrolling employer subsidy under section 2234(a)(1)(B).

''(B) ONLY 1 OFFERS QUALIFIED PLAN.—In the case of an unmarried individual who is a full-time employee of more than 1 employer, if only 1 employer offers the employee enrollment under a qualified employer health plan—

''(i) the individual shall be enrolled under such plan and, pursuant to subsection (c)(2) of section 3151 of the Internal Revenue Code of 1986, is not subject

to taxes under subsection (a)(2) of such section with respect to employment with nonenrolling employers, and

''(ii) the enrolling employer is eligible for an enrolling employer subsidy under section 2234(a)(1)(B).

''(b) MARRIED EMPLOYEES.—

''(1) IN GENERAL.—Except as provided in this part, each employer shall, in accordance with this title, enroll each of its full-time employees who is married in a qualified employer health plan.

''(2) BOTH FULL-TIME EMPLOYEES.—In the case of married individuals, if both are full-time employees of 1 or more employers, rules established by the Secretary based on the rules under subsection (a)(2) for multiple employment of unmarried individuals shall apply.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as preventing the nonenrolling plan from supplementing the benefits of the enrolling plan.

''(d) DEFINITIONS.—In this section, the terms 'enrolling employer' and 'enrolling plan' mean, with respect to an individual or a married couple, the employer that offers the qualified employer health plan in which the individual or couple is enrolled under subsection (a)(2)(A)(i)

or (b)(2)(A)(i) and such plan, respectively, and the terms 'nonenrolling employer' and 'nonenrolling plan' mean the other employer and other qualified employer health plan, respectively.

"SEC. 2102. APPLICATION TO PART-TIME EMPLOYEES.

''(a) APPLICATION OF FULL-TIME EMPLOYEE RULES.—Subject to subsection (b), the provisions of section 2101 shall apply to part-time employees in the same manner as they apply to full-time employees.

''(b) SEPARATE TREATMENT OF PART-TIME AND FULL-TIME EMPLOYEES UNDER QUALIFIED EMPLOYER HEALTH PLANS.—For rule regarding separate, but uniform, treatment of full-time and part-time employees (and family members), see section 2104(b).

"SEC. 2103. APPLICATION TO SEASONAL AND TEMPORARY EMPLOYEES.

''(a) ENROLLMENT UNDER QUALIFIED EMPLOYER HEALTH PLAN NOT AFFECTING APPLICATION OF EXCISE TAX.—The enrolling by an employer of an employee designated under subsection (b) as a seasonal or temporary employee (as defined in section 2181(b)(3)), whether a part-time or full-time employee, under the qualified employer health plan of the employer shall not be considered, for purposes of section 3151 of the Internal Revenue Code

of 1986, coverage of the employee under a qualified employer health plan.

''(b) DESIGNATION OF SEASONAL OR TEMPORARY EMPLOYEES.—Each employer shall designate, at the time of initial employment and in a manner specified by the Secretary, if the individual is to be treated under this title and title XXII as a seasonal or temporary employee.

"SEC. 2104. TREATMENT OF ALL FAMILY MEMBERS AS A UNIT; UNIFORM TREATMENT OF FULL-TIME EMPLOYEES AND OF PART-TIME EMPLOYEES.

''(a) TREATMENT OF ALL FAMILY MEMBERS AS A UNIT.—

''(1) IN GENERAL.—In accordance with section 2152(a), enrollment of an employee in a qualified employer health plan shall include enrollment of the other family members of the employee.

''(2) TREATMENT OF CHILDREN.—In the case of an individual who is a child, the employer of the child is not required to enroll the child in a qualified employer health plan by virtue of the part-time or full-time employment of the child (whether or not the parent of the child is a full-time or part-time employee). However, the employer is liable for taxes under section 3151(a)(1) of the Internal Revenue Code of 1986 (or payment of a nonenrolling em-

ployer premium under section 2234(a)(1)(A)) with respect to such employment, and the child is, subject to section 3151(c)(2) of such Code, liable for taxes under section 3151(a)(2) of such Code.

''(b) UNIFORM TREATMENT OF FULL-TIME EMPLOYEES AND OF PART-TIME EMPLOYEES.—Except as authorized under sections 2101 and 2102 (with respect to permitting certain multiple-employed individuals to elect coverage under qualified employer health plans) and as provided under section 2103 and subsection (a)(2) of this section, an employer health plan is not a qualified employer health plan if the plan—

''(1) enrolls some (but not all) full-time employees (and family members) required to be enrolled under this part, or

''(2) enrolls some (but not all) part-time employees (and family members) required to be enrolled under this part.

However, a plan may be a qualified employer health plan and enroll only full-time employees (and family members), but not part-time employees (and family members).

"SEC. 2105. APPLICATION OF REQUIREMENT TO EMPLOYERS OF DIFFERENT SIZES.

''(a) IN GENERAL.—Except as provided in subsection (b), the requirements of this part apply—

''(1) as of January 1, 1994, to very large employers;

''(2) as of January 1, 1995, to large employers;

''(3) as of January 1, 1996, to medium-size employers; and

''(4) as of January 1, 1997, to small employers.

''(b) TRANSITION FOR COLLECTIVE BARGAINING AGREEMENTS.—The requirements of this part shall not apply to employers with respect to their employees, insofar as such employees are covered under a collective bargaining agreement ratified before the date of the enactment of this title, earlier than the date of termination of such agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this title).

"SEC. 2106. TIMING OF ENROLLMENT; PERIOD OF COVERAGE.

''(a) TIMING OF ENROLLMENT; NOTICES.—

''(1) IN GENERAL.—Enrollment under this part shall occur not later than the date on which the employment, for which such enrollment is required under this part, commences.

''(2) REFERENCE TO DISCLOSURE REQUIREMENT.—For requirement for disclosure to employees of information respecting the availability of low-in-

come assistance under part E of title XXII, see section 2158(a)(1).

''(b) PERIOD OF COVERAGE.—

''(1) BEGINNING OF COVERAGE.—Coverage under a qualified employer health plan shall begin in accordance with section 2152(b).

''(2) TERMINATION OF COVERAGE.—

''(A) IN GENERAL.—If an enrollment is effected under this part on the basis of employment, coverage under such enrollment may be terminated, subject to subparagraph (B), on the last day of the month (or of any subsequent month) during which such employment is terminated.

''(B) NOTICE REQUIRED.—Effective on the date specified in section 2157(b)(2), coverage under a qualified employer health plan shall not be terminated unless notice has been provided to the Secretary, as required in section 2157(b)(1), of such termination at least 7 days before the last day of the month in which employment is terminated (or any subsequent month).

''(3) TREATMENT OF FAMILY MEMBERS.—Subject to section 2152, the period of coverage for fam-

ily members of an employee shall be the same as the period of coverage for the employee.

''PART B—REQUIREMENTS FOR QUALIFIED EMPLOYER HEALTH PLANS

"SEC. 2121. QUALIFIED EMPLOYER HEALTH PLAN DEFINED.

''(a) IN GENERAL.—In this title and title XXII, subject to subsection (b), the term 'qualified employer health plan' means an employment-related health plan (as defined in section 2304(a)(2)) that—

''(1) is a qualified health plan (as defined in section 2151(a)),

''(2) except as provided in section 2122, does not impose premiums, deductibles, or copayments on employees (and family members) required to be enrolled in a qualified employer health plan under part A, and

''(3) meets the requirements of section 2243(c)(3) (relating to coordination of low-income assistance for deductibles).

''(b) TYPES OF QUALIFIED EMPLOYER HEALTH PLANS.—

''(1) LARGE EMPLOYERS.—A very large or large employer may meet the requirements of this title through a qualified employer health plan that is an insured plan or that is a self-insured plan.

''(2) MEDIUM-SIZE AND SMALL EMPLOYERS.—A medium-size or small employer may meet the requirements of this title only through a qualified employer health plan that is an insured plan or through the public health plan under title XXII.

''(3) INSURED PLAN DEFINED.—The term 'insured plan' has the meaning given the term 'applicable accident and health insurance contract' in section 5000B(e)(1) of the Internal Revenue Code of 1986.

"SEC. 2122. REQUIREMENTS RELATING TO EMPLOYEE PREMIUMS AND COST-SHARING.

''(a) ENROLLEE PREMIUMS AND COST-SHARING PERMITTED.—

''(1) IN GENERAL.—A qualified employer health plan may require an enrollee to pay for—

''(A) premiums for coverage under the plan, but only if the premiums do not exceed the limitations imposed under this section, and

''(B) cost-sharing amounts for coverage under the plan, but only if the cost-sharing does not exceed the limitations on deductibles, copayments, and coinsurance imposed with respect to qualified health plans under section 2155.

''(2) TREATMENT OF ADDITIONAL, REQUIRED COVERAGE.—If a qualified employer health plan provides benefits in addition to the benefits required under this title and the employee is not permitted the option of not accepting such additional benefits, the plan—

''(A) may not impose a premium, for such required and additional benefits, that exceeds the premiums that may be imposed for the basic benefits, and

''(B) shall assure that cost-sharing is not imposed with respect to required health services once the cost-sharing limit has been reached in a year with respect to benefits for such services.

''(3) NONDISCRIMINATION IN PREMIUM AMOUNTS.—Under a qualified employer health plan, no employee may be charged a different premium for similar benefits in the same employer health plan for the same beneficiary class based on the age or sex of the employee.

''(b) LIMITATION ON PREMIUMS.—

''(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

''(A) IN GENERAL.—A qualified employer health plan may not require an employee to pay a premium—

''(i) for coverage for a period of longer than one month, or

''(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate (as defined under subparagraph (B)).

''(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this subsection, the term 'monthly actuarial rate' means, with respect to a qualified employer health plan in a plan year, the average monthly per enrollee amount that the plan estimates, for enrollees under the plan during the year, would be necessary to pay for the total benefits required during the year under the plan (with respect to required health services), including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin.

''(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of subparagraph (B), a qualified employer health plan may provide for

the premium to be applied, and the monthly actuarial rate described in such subparagraph to be estimated, for required health services based on the beneficiary classes described in section 2231(d)(1) or on such other beneficiary classifications, consistent with subsection (a), as the employer or plan may specify.

''(3) LIABILITY FOR PAYMENT OF PREMIUMS.—An employee enrolled under a qualified employer health plan is liable for payment of premiums required under that plan in accordance with this subsection. In no case shall an employee be liable for premiums with respect to a qualified employer health plan, other than the portion of the premium which may be imposed on the employee consistent with this section.

''(4) WITHHOLDING PERMITTED.—No provision of State law shall prevent an employer of an employee enrolled under a qualified employer health plan from withholding the amount of any premium due by the employee under this subsection from the wages paid the employee.

''(5) CONSTRUCTION.—Nothing in this section shall be construed—

''(A) as preventing an employer from paying part or all of the employee premium for required health services or other health services, or

''(B) subject to subsection (a), from requiring an employee to pay for all or part of the premium for benefits for services other than required health services.

''PART C—STANDARDS FOR QUALIFIED HEALTH PLANS

"SEC. 2151. CERTIFICATION OF QUALIFIED HEALTH PLANS.

''(a) QUALIFIED HEALTH PLAN DEFINED.—For purposes of this title, the term 'qualified health plan' means a health plan that the Secretary certifies, upon application by the plan, to meet the requirements of this part.

''(b) REVIEW AND RECERTIFICATION.—The Secretary shall establish procedures for the periodic review and recertification of plans as qualified health plans.

''(c) TERMINATION OF CERTIFICATION.—The Secretary shall terminate the certification of a qualified health plan if the Secretary determines that the plan no longer meets the requirements for certification. Before effecting a termination, the Secretary shall provide the plan notice and opportunity for a hearing on the proposed termination.

''SEC. 2152. TREATMENT OF FAMILY AS A UNIT; COVERAGE PERIOD; HEALTH PLAN CARDS.

''(a) TREATMENT OF FAMILY AS A UNIT.—

''(1) IN GENERAL.—Subject to paragraph (2), enrollment of an individual in a qualified health plan shall include enrollment of the other family members (as defined in section 2282(1)) of the individual.

''(2) TREATMENT OF INELIGIBLE INDIVIDUALS.—Nothing in paragraph (1) shall be construed as requiring a qualified health plan (or permitting the public health plan) to enroll individuals who are not eligible individuals (as defined in section 2201(d)).

''(b) BEGINNING OF COVERAGE.—

''(1) IN GENERAL.—In the case of an individual enrolled under any qualified health plan, subject to subsection (c), the benefits under the plan shall first become available for services furnished beginning on the first day of the month following the month of enrollment.

''(2) SPECIAL RULES.—The Secretary shall provide for such standards as may be necessary to provide for the allocation of responsibility among qualified health plans (including the public health plan under title XXII) in the case of an inpatient hospital stay, or in the case in which a single payment

amount if made for other services provided over a period of time, that begins during the period of coverage under one qualified health plan and ends during a period of coverage under another qualified health plan.

''(c) STANDARDS TO REFLECT CHANGES IN FAMILY AND EMPLOYMENT STATUS.—

''(1) IN GENERAL.—Under standards established by the Secretary consistent with this subsection, qualified health plans shall provide for appropriate changes in the coverage of family members to take into account—

''(A) changes in family composition or status, including marriage, divorce (or legal separation), birth or adoption of children, and the aging of children into adulthood, and

''(B) changes in employment status.

''(2) MONTHLY CHANGES.—Except as specifically provided in this subsection, such standards shall be designed—

''(A) to effect a change in enrollment (or status of enrollment) as of the first day of the first month (or, in order to provide for notice and an opportunity for coordination among

plans, a later month) following the date of the event causing the change,

''(B) to prevent any periods of noncoverage under any qualified health plans, and

''(C) to provide, in the case of a change of family status such as marriage, divorce, or legal separation, for accounting and crediting of cost-sharing among family members (described in section 2157(c)) in an equitable and administrable manner.

''(3) TREATMENT OF NEWBORNS.—

''(A) BIRTH TO WOMAN DURING PERIOD OF COVERAGE.—Any child born to a woman during the period of coverage under a qualified health plan shall, as of the date of birth, be automatically enrolled and covered for benefits under the plan.

''(B) BIRTH TO WOMAN WITHOUT COVERAGE.—Any child born in the United States to a woman who is not, at the time of birth, enrolled under a qualified health plan shall be automatically enrolled and covered for benefits under this title as of the date of birth if an application for such enrollment is made not later

than 60 days after the date of birth or, if later, the end of the year in which the child is born.

''(4) ADOPTION.—

''(i) TREATMENT OF VOLUNTARY RELINQUISHMENT.—Any child who is voluntarily relinquished to a public or private agency shall, upon the application by the agency, be enrolled under this title and covered as of the date of the relinquishment, until the date of the child's placement for adoption.

''(ii) TREATMENT OF ADOPTED CHILDREN.—Any child who is placed for adoption with an individual during the period the individual is enrolled and covered under a qualified health plan shall, as of the date of the placement for adoption, be treated as the child of the individual and be automatically enrolled and covered under such plan.

''(5) PLACEMENT IN CUSTODY OF PUBLIC AGENCY PURSUANT TO COURT ORDER OR OTHERWISE.—Any child who is removed from the family and placed in the temporary custody of a public agency pursuant to a court order or otherwise shall, upon application by the public agency on or after the date of the removal and placement with the public

agency, be deemed to be automatically enrolled and covered for benefits under this title as of the date of the application, until the child is returned to the family or placed for adoption.

''(6) TREATMENT OF LEGAL WARDS, FOSTER CHILDREN, ETC.—In cases not described in paragraphs (4) or (5), the Secretary shall establish standards relating to the time an individual described in section 2282(5)(B)(ii) is treated as the child of the person with custody and such other standards as may be necessary to assure the proper coordination of enrollment of children and other individuals among qualified health plans.

''(d) HEALTH PLAN CARDS.—In conjunction with enrollment of individuals under a qualified health plan, the plan shall provide for the issuance of a card which may be used for purposes of identification of such enrollment and the processing of claims for benefits under the plan. Such card shall—

''(1) identify (as appropriate) the types of benefits to which the individual is entitled under the plan, and

''(2) contain such other information as the Secretary (and the plan) shall specify.

"SEC. 2153. REQUIREMENTS RESPECTING BASIC BENEFITS.

''(a) IN GENERAL.—Each qualified health plan must provide for benefits for at least all required health services (as defined in section 2211(a)(2)).

''(b) TREATMENT OF ADDITIONAL BENEFITS.—Nothing in this section shall be construed as preventing a qualified health plan from including benefits in addition to benefits for required health services.

"SEC. 2154. REQUIREMENTS RESPECTING LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS AND COVERAGE STANDARDS FOR BASIC HEALTH SERVICES.

''(a) IN GENERAL.—Except as provided under subsection (b), a qualified health plan—

''(1) may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to basic health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual, and

''(2) may not provide for exclusions from coverage for basic health services that are more restrictive than the exclusions for such services under this title.

''(b) TREATMENT OF PRE-EXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a qualified health plan (other than the public health plan) may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months.

''(2) NONAPPLICATION TO NEWBORNS AND SUNSET OF PRE-EXISTING CONDITION EXCLUSIONS FOR BASIC HEALTH SERVICES.—The exclusion of coverage permitted under paragraph (1) shall not apply to—

''(A) services furnished to newborns, or

''(B) basic health services furnished on or after July 1 of the 4th year beginning after the date of the enactment of this title.

''(3) CREDITING OF PREVIOUS COVERAGE.—

''(A) IN GENERAL.—If an individual is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under a plan, any period of exclusion of coverage with respect to a pre-existing condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

''(B) DEFINITIONS.—In this paragraph:

''(i) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health plan or program (including a qualified health plan, a Federal health plan, the medicare program, a State plan under title XIX, or a State general medical assistance program) which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

''(ii) PRE-EXISTING CONDITION.—The term 'pre-existing condition' means, with respect to coverage under a plan, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage, except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

''(C) STANDARDS FOR SIMILAR BENEFITS.—The Secretary shall establish such criteria for determining if benefits are substantially similar as may be necessary to carry out this subsection.

"SEC. 2155. REQUIREMENTS RESPECTING LIMITS ON COST-SHARING.

''(a) IN GENERAL.—A qualified health plan may not impose deductibles, copayments, or coinsurance with respect to required health services in excess of the deductible and coinsurance permitted under part C of title XXII with respect to such services (not taking into account any low-income assistance provided under part E of title XXII).

''(b) CONSTRUCTION.—Nothing in this section shall be construed as preventing a qualified health plan from providing for deductibles, coinsurance, and copayments or other restrictions with respect to services other than required health services that are different from those permitted with respect to required health services.

"SEC. 2156. USE OF PAYMENT RATES.

''A qualified health plan shall establish adequate payment rates for required health services using the payment rates approved under title III of the Health Insurance Coverage and Cost Containment Act of 1993.

"SEC. 2157. COORDINATION AND PORTABILITY OF HEALTH COVERAGE UNDER QUALIFIED HEALTH PLANS.

''(a) IN GENERAL.—Each qualified health plan shall provide for coordination of—

''(1) enrollment and termination of enrollment among the qualified health plans, the public health plan, and title XVIII, and

''(2) application of deductibles and limitations on cost-sharing among such plans,

in accordance with standards established by the Secretary consistent with this section.

''(b) REQUIREMENT OF NOTICES WITH RESPECT TO COVERAGE.—

''(1) IN GENERAL.—Each qualified health plan shall provide notice at the time an individual's coverage under the plan begins or is terminated. Such notice shall be provided (in a form and manner and at a time specified by the Secretary)—

''(A) to the individual (or in the case of enrollment only of a child or children, to the parent enrolling the child or children), and

''(B) effective (on the date specified in paragraph (2)) to the Secretary.

The notice under this paragraph shall include the names and other identifying information of family members whose coverage is affected by the change.

''(2) DATE OF REQUIREMENT FOR NOTICE TO PUBLIC HEALTH PLAN.—The date specified in this paragraph is January 1, 1994, or, with respect to a qualified employer health plan of an employer, the date the requirements of part A apply with respect to the employer under section 2105(a).

''(3) NOTICE TO BENEFICIARY AND OTHER QUALIFIED HEALTH PLANS UPON OBTAINING COVERAGE.—In the case of an individual who begins coverage under a qualified employer health plan (or under this title on an employment basis), when the Secretary receives notice under paragraph (1)(B)—

''(A) if, at the time of obtaining such coverage, the individual is enrolled on a non-employment basis in the public health plan, the Secretary shall notify the individual that coverage for such services on such a basis or for such benefits shall be terminated effective on the date of coverage under such a plan, and

''(B) the Secretary shall provide for notice to any other qualified health plan in which the

Secretary knows the individual is enrolled of the fact of such new coverage.

''(4) NOTICES OF TERMINATION.—Each notice of termination under paragraph (1) shall include—

''(A) the effective date of the termination,

''(B) in the case of notice to the Secretary, sufficient information to permit enrollment of the individuals affected under the public health plan, and

''(C) in the case of an individual whose coverage under the plan is terminated other than at the end of a calendar year, the accounting statement produced under subsection (c)(2).

''(c) ACCOUNTING FOR COST-SHARING.—

''(1) IN GENERAL.—Each qualified health plan shall provide for an ongoing accounting, for each enrollee (and enrolled family members) on a calendar year basis, of expenses incurred for required health services that are counted towards the deductible established under section 2222 and that are counted towards the cost-sharing limit established under section 2224. The amount credited for each account shall be determined in accordance with standards established by the Secretary in order to provide consistency among qualified health plans and to pro-

mote portability of benefits across qualified health plans.

''(2) STATEMENT OF ACCOUNT BALANCE.—In the case of an individual whose coverage under the plan is terminated other than at the end of a calendar year, the qualified health plan shall produce an accounting statement (in a uniform manner established by the Secretary) of the amounts that are credited under the plan towards such deductible and cost-sharing limitations for the year for each enrollee (and family members) involved, in accordance with the accounting under paragraph (1).

''(3) CREDITING OF PREVIOUS EXPENSES TOWARDS DEDUCTIBLES AND COINSURANCE.—Each qualified health plan shall, in the case of an individual who is enrolled under the plan after the beginning of a year, credit, against the deductible and cost-sharing limit for required health services under its plan, the amounts previously accounted against the deductible and cost-sharing limit under another qualified health plan for the calendar year. The credit under this subparagraph shall be based on the accounting statement produced under paragraph (2).

''(d) COVERAGE UNDER PUBLIC HEALTH PLAN.—

''(1) IN GENERAL.—Except as provided in this subsection, the public health plan under title XXII shall enroll each eligible individual whose coverage under another qualified health plan or under title XVIII is terminated, effective on the date following the effective date of termination of coverage under such plan.

''(2) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Except as provided in paragraphs (3) and (4), in the case of an individual who—

''(A) is eligible for enrollment under part B of title XVIII,

''(B) is not so enrolled because of enrollment under a qualified health plan, but

''(C) whose enrollment under such a plan is terminated,

the Secretary shall provide, upon the effective date of such termination, for enrollment of the individual under such part.

''(3) OBTAINING ALTERNATE COVERAGE.—Paragraphs (1) and (2) shall not apply if the individual provides satisfactory evidence that the individual has obtained coverage through another qualified health plan or is a medicare beneficiary enrolled under part B of title XVIII.

''(4) NO AUTOMATIC ENROLLMENT DURING TRANSITION.—Paragraphs (1) and (2) shall not apply to terminations occurring before January 1, 1997. During the period before January 1, 1997, before an individual described in paragraph (1) enrolls under this title, the Secretary shall provide the individual with a notice of the minimum enrollment period required under section 2202(a)(3).

''(e) PROVISION OF INFORMATION ON ENROLLEES.—Each qualified health plan shall provide the Secretary with such information as the Secretary may require in order to ascertain whether (and the amount of) any transfer payments to be made under section 2234.

"SEC. 2158. CONSUMER PROTECTIONS.

''(a) DISCLOSURE REQUIREMENTS FOR EMPLOYER PLANS.—

''(1) NOTICE OF AVAILABILITY OF LOW-INCOME ASSISTANCE.—At the time of enrollment of an employee under a qualified employer health plan, the plan (directly or through the employer) shall provide the employee with a notice (in a form specified by the Secretary) of the low-income assistance available under part E of title XXII with respect to enrollment under the plan.

''(2) FOR SMALL EMPLOYER PLANS.—In the case of a qualified employer health plan that is offered to a small employer, the plan may not be issued or sold to the employer unless the employer has been provided, in addition to any information required to be disclosed under paragraph (1), the following information:

''(A) A description of the benefits covered in the plan and cost-sharing required with respect to such benefits.

''(B) A comparison of the benefits and cost-sharing described in subparagraph (A) with the benefits and cost-sharing available under the public health plan (not taking into account any low-income assistance under part E of title XXII).

''(3) STANDARD FORMAT.—The disclosures under paragraphs (1) and (2) shall be made in a uniform format established by the Secretary.

''(4) VIOLATIONS.—Any entity that issues or sells a qualified health plan in violation of paragraph (1) or (2) is subject to a civil money penalty of an amount not to exceed $5,000 with respect to each such issuance or sale. The provisions of section 1128A (other than the first sentence of subsection

(a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(b) EFFECTIVE GRIEVANCE PROCEDURES.—Each qualified health plan shall provide for effective procedures for hearing and resolving grievances between the plan and individuals enrolled under the plan.

''(c) RESTRICTION ON CERTAIN PHYSICIAN INCENTIVE PLANS.—

''(1) IN GENERAL.—A health plan is not a qualified health plan if it operates a physician incentive plan (as defined in paragraph (2)) unless the requirements specified in clauses (i) through (iii) of section 1876(i)(8)(A) are met (in the same manner as they apply to eligible organizations under section 1876).

''(2) PHYSICIAN INCENTIVE PLAN DEFINED.—In this subsection, the term 'physician incentive plan' means any compensation or other financial arrangement between the qualified health plan and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled under the plan.

''(d) ENROLLEE FINANCIAL PROTECTION.—

''(1) SOLVENCY PROTECTION FOR INSURED PLANS.—In the case of a qualified health plan that is an insured plan (as defined by the Secretary) and is issued in a State, in order for the plan to be certified under this part the Secretary must find that the State has established satisfactory protection of enrollees with respect to potential insolvency.

''(2) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of a qualified health plan to make payments with respect to required health services, under standards established by the Secretary, an individual who is enrolled under the plan is not liable to any health care provider or practitioner with respect to the provision of required health services for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

"SEC. 2159. PREEMPTION OF CERTAIN STATE AND FEDERAL REQUIREMENTS.

''(a) BENEFIT AND COVERAGE RULES.—Effective as of January 1, 1994, no State shall establish or enforce any law or regulation that—

''(1) requires the offering, as part of a qualified employer health plan, of any services, category of care, or services of any class or type of provider that is different from the benefits required to be provided under section 2153,

''(2) specifies the individuals to be covered under a qualified employer health plan or the duration of such coverage, or

''(3) requires a right of conversion from a qualified employer health plan to an individual qualified health plan.

''(b) STATE DEFINED.—In this section, the term 'State' means the 50 States and the District of Columbia.

"SEC. 2160. USE OF UNIFORM CLAIMS FORMS; UNIFORM INFORMATION REPORTING.

''Each qualified health plan shall provide for—

''(1) submission of claims in accordance with section 323 of the Health Insurance Coverage and Cost Containment Act of 1993, and

''(2) reporting to the Commission of information on required health services provided under the plan pursuant to standards promulgated under section 324 of such Act.

''PART D—DEFINITIONS AND MISCELLANEOUS

"SEC. 2181. DEFINITIONS.

''(a) WAGES, EMPLOYMENT, ETC.—In this title—

''(1) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) of the Internal Revenue Code of 1986 except that—

''(A) the modifications of subsection (b) shall apply in determining whether any service is employment, and

''(B) the applicable contribution base under section 3121(x)(2) of such Code (relating to hospital insurance) shall be used under section 3121(a)(1) for purposes of this title.

''(2) EMPLOYMENT.—

''(A) IN GENERAL.—Except as modified in subparagraph (B), the term 'employment' has the meaning given such term by section 3121(b) of the Internal Revenue Code of 1986.

''(B) MODIFICATIONS.—The modifications referred to in this paragraph are that—

''(i) paragraphs (5), (6), (7), (8), and (9) of section 3121(b) of such Code shall not apply, and

''(ii) subsections (r) and (w) of section 3121 of such Code shall not apply.

''(C) TREATMENT OF FEDERAL EMPLOYMENT.—In applying subparagraph (A), the term 'employment' shall not be considered to include service performed in the employ of the United States if, in connection with the performance of such service (or the service of a family member), the individual—

''(i) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

''(ii) is provided medical and dental benefits under chapter 55 of title 10, United States Code.

''(3) EMPLOYEE; EMPLOYER.—The terms 'employee' and 'employer' have the same meanings as such terms have for purposes of chapter 21 of the Internal Revenue Code of 1986.

''(b) DEFINITIONS RELATING TO EMPLOYEES.—In this title:

''(1) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 17½ hours of service per week for that employer.

''(2) PART-TIME EMPLOYEE.—The term 'part-time employee' means, with respect to an employer, an employee who is not a full-time employee.

''(3) SEASONAL OR TEMPORARY EMPLOYEE.—The term 'seasonal or temporary employee' means, with respect to an employer, an employee who is employed by the employer for not more than 4 months in any 12 month period; except that the Secretary may extend such period for up to 6 months in any 12 month period in the case of employment that is sporadic, irregular, and seasonal in nature.

''(4) TREATMENT OF CONSULTANTS AND CONTRACTORS.—The term 'employee' includes an individual who is a consultant or contractor of an employer if the Secretary determines that the consulting arrangement or contract was entered into to avoid the requirements of this title.

''(5) EXCLUSION OF FOREIGN EMPLOYMENT.—The term 'employee' does not include an individual—

''(A) who is not a citizen or resident of the United States with respect to service performed outside the United States, or

''(B) who is a citizen or resident of the United States with respect to services per-

formed outside the United States for an employer other than an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986).

''(c) DEFINITIONS RELATING TO SIZE OF EMPLOYER.—In this title:

''(1) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 50 employees on a typical business day during the calendar year.

''(2) MEDIUM-SIZE EMPLOYER.—The term 'medium-size employer' means, with respect to a calendar year, an employer that normally employs at least 50, but fewer than 101, employees on a typical business day during the calendar year.

''(3) LARGE EMPLOYER.—The term 'large employer' means, with respect to a calendar year, an employer that normally employs at least 100, but fewer than 250, employees on a typical business day during the calendar year.

''(4) VERY LARGE EMPLOYER.—The term 'very large employer' means, with respect to a calendar year, an employer that normally employs at least

250 employees on a typical business day during the calendar year.

''(4) APPLICATION OF CONTROLLED GROUP RULES.—For purposes of determining if an employer is a small, medium-size, large, or very large employer or the number of hours an individual is normally employed with respect to an employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

''(d) INCORPORATION OF DEFINITIONS.—Except as otherwise provided in this title, the terms defined in section 2282 and 2283 shall apply under this title in the same manner as they apply under title XXII.

"SEC. 2182. NONAPPLICATION TO RESIDENTS OF PUERTO RICO AND TERRITORIES.

''The provisions of this title shall not apply with respect to an employee who is not a resident of one of the 50 States or the District of Columbia.''.

SEC. 103. REPEAL OF COBRA CONTINUATION REQUIREMENTS.

(a) INTERNAL REVENUE CODE PROVISIONS.—

(1) IN GENERAL.—Section 4980B of the Internal Revenue Code of 1986 is repealed.

(2) CONFORMING AMENDMENTS.—Section 414 of such Code is amended—

(A) in subsection (n)(3)(C), by striking ''505, and 4980B'' and inserting ''and 505'', and

(B) in subsection (t)(2), by striking ''505, or 4980B'' and inserting ''or 505''.

(b) ERISA.—

(1) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is repealed.

(2) CONFORMING AMENDMENT.—Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606 or''.

(c) PUBLIC HEALTH SERVICE ACT.—Title XXII of the Public Health Service Act is repealed.

(d) EFFECTIVE DATE.—The repeals and amendments made by this section shall apply to health plans of employers as of the date specified with respect to employers of that size under section 2105 of the Social Security Act.

(e) NOTICE OF BENEFITS UNDER PUBLIC HEALTH PLAN.—In the case of continuation coverage which is in effect on the date of a repeal under this section but which

is to be discontinued after such date (and before the date required under law in effect before the date of the enactment of this Act) such continuation may not be discontinued without 30-days notice to the individual of such discontinuation. Such notice shall include such information respecting continuation of coverage through enrollment under the public health plan under title XXII of the Social Security Act as the Secretary of Health and Human Services shall specify.

TITLE II—PROVISION OF HEALTH INSURANCE THROUGH A PUBLIC HEALTH PLAN

SEC. 201. PUBLIC HEALTH PLAN.

The Social Security Act is amended by adding after the title added by section 101 the following new title:

''TITLE XXII—PUBLIC HEALTH PLAN

''PART A—ELIGIBILITY AND ENROLLMENT

''SEC. 2201. ELIGIBILITY TO ENROLL FOR HEALTH INSURANCE BENEFITS AND TO APPLY FOR LOW-INCOME ASSISTANCE.

''(a) ELIGIBILITY TO ENROLL FOR HEALTH INSURANCE BENEFITS.—

''(1) IN GENERAL.—Subject to paragraph (2), each eligible individual (as defined in subsection (d))

who is not a medicare beneficiary and who is not enrolled under a qualified employer health plan pursuant to title XXI or under a Federal health plan (as defined in section 2204(f)) is eligible to enroll under this title for health insurance benefits.

''(2) ENROLLMENT BY ELECTING SMALL OR MEDIUM-SIZE EMPLOYERS.—In order to meet the requirements of title XXI, a small or medium-size employer may provide for the enrollment of full-time employees (and family members) in the plan under this title in a manner specified by the Secretary, but only if—

''(A) the employer complies with the requirements of section 2122 with respect to the plan under this title as if the plan under this title were a qualified employer health plan; and

''(B) provides for payment of premiums (in the amounts specified in section 2231) in a manner specified by the Secretary.

''(3) EFFECTIVE DATE.—No health insurance benefits are available under this title for items and services furnished before January 1, 1994, or, for individuals enrolled under this title as employees (or dependents) of medium-size or small employers, before January 1, 1996, or 1997, respectively.

''(b) ELIGIBILITY TO APPLY FOR LOW-INCOME ASSISTANCE.—

''(1) IN GENERAL.—Subject to paragraph (2), each eligible individual who—

''(A) is enrolled in the public health plan under this title, whether on a non-employment basis or on an employment basis,

''(B) is enrolled under a qualified employer health plan, or

''(C) is a medicare beneficiary,

is eligible to apply for low-income assistance under part E.

''(2) EFFECTIVE DATE.—No low-income assistance is available for premiums for months before January 1997 or for expenses incurred for any items or services furnished before January 1, 1997.

''(c) ENROLLMENT TERMS.—

''(1) ENROLLMENT UNDER TITLE ON AN EMPLOYMENT AND NON-EMPLOYMENT BASIS DEFINED.—An eligible individual is considered, for purposes of this title, to be enrolled under this title—

''(A) on an 'employment basis' only if the individual is enrolled by a small employer pursuant to the requirement of section 5000A of the Internal Revenue Code of 1986, or

''(B) on a 'non-employment basis' in any other case.

''(2) ENROLLMENT UNDER A QUALIFIED EMPLOYER HEALTH PLAN DEFINED.—An individual is considered, for purposes of this title, to be 'enrolled under a qualified employer health plan' if—

''(A) the individual is enrolled under a qualified employer health plan (as defined in section 2281(b)(8)) as an employee (or family member of an employee),

''(B) the employer is required to provide for such enrollment under part A of title XXI, and

''(C) the amount of the employee share of the premium is limited under section 2122(b).

''(d) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term 'eligible individual' means an individual who is—

''(1)(A) a citizen or national of the United States, (B) an alien lawfully admitted for permanent residence, or (C) an alien otherwise residing permanently in the United States under color of law, and

''(2) a resident of the United States.

"SEC. 2202. APPLICATION FOR ENROLLMENT.

''(a) PERIOD OF APPLICATION.—Individuals eligible to enroll under this title may apply to enroll at any time at which they are so eligible.

''(b) APPLICATION PROCESS.—

''(1) IN GENERAL.—The filing of an application for enrollment under this title shall (except as the Secretary may provide) constitute enrollment under this title. Such an application may be filed with the Secretary by mail or at such locations as the Secretary may specify.

''(2) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for enrollment under this title available—

''(A) at local offices of the Social Security Administration,

''(B) at out-reach sites (such as provider and practitioner locations), and

''(C) at other locations (including post offices) accessible to a broad cross-section of individuals eligible to enroll.

''(3) APPLICATION FOR LOW-INCOME ASSISTANCE.—An application for enrollment under this section may (but need not) be accompanied by an application for low-income assistance under part E.

''(4) RESTRICTION ON USE OF AGENTS.—The Secretary may not provide for receipt or processing of applications for enrollment under this title—

''(A) by any non-Federal entity which is directly or indirectly involved in the administration of title IV, XVI, or XIX of this Act, or

''(B) by any entity which does not meet such standards as the Secretary establishes to assure the confidentiality of information collected in the enrollment process.

"SEC. 2203. COVERAGE PERIOD; TERMINATION OF ENROLLMENT.

''(a) BEGINNING OF COVERAGE.—The provisions of section 2152(b) shall apply to the public health plan in the same manner as they apply to qualified health plans.

''(b) TERMINATION OF ENROLLMENT DURING TRANSITION PERIOD.—

''(1) IN GENERAL.—Before January 1, 1997, except as provided in paragraph (3)—

''(A) an individual enrolled under this title may terminate enrollment on a non-employment basis by providing written notice to the Secretary that the individual—

''(i) no longer wishes to be enrolled in the public health plan, or

''(ii) is enrolled under a qualified employer health plan or is a medicare beneficiary; and

''(B) the Secretary may terminate enrollment on a non-employment basis of an individual, after providing the individual (or the individual's representative) with written notice, for failure to pay premiums required with respect to such enrollment.

The termination of enrollment of an individual (other than due to the individual becoming a medicare beneficiary) shall terminate the enrollment of other family members enrolled with the individual.

''(2) EFFECTIVE DATE OF TERMINATION.—A termination of enrollment under paragraph (1)(A) shall take effect at the close of the month following the month in which the notice is filed. A termination of enrollment under paragraph (1)(B) shall take effect on a date (determined under regulations) after the date written notice of such termination has been provided to the enrollee (or the enrollee's representative). Such regulations shall provide a grace period of at least 1 month after the date of written notice in which overdue premiums may be paid and coverage continued.

''(3) MINIMUM PERIOD OF ENROLLMENT DURING TRANSITION.—Subject to paragraph (4), before January 1, 1997—

''(A) IN GENERAL.—An individual (other than a pregnant woman or newborn) who is enrolled under this title on a non-employment basis may not terminate enrollment less than 12 months after the date of the enrollment.

''(B) PREGNANT WOMEN AND NEWBORNS.—In the case of a pregnant woman who is enrolled under this title on a non-employment basis—

''(i) the enrollment of the woman may not be terminated earlier than the end of the month in which the 60-day period, beginning on the last day of the pregnancy, ends; and

''(ii) the newborn child shall be deemed enrolled under this title as of the date of birth, and such enrollment may not be terminated earlier than the end of the month in which the child's first birthday occurs.

''(4) TERMINATION PERMITTED IF COVERED UNDER QUALIFIED EMPLOYER HEALTH PLAN.—The

minimum period of enrollment under paragraph (3) shall not apply if, at the time of termination of enrollment, the individual is immediately covered under a qualified employer health plan which will provide coverage during the minimum period for which enrollment is otherwise required under such paragraph.

''(c) TERMINATION OF ENROLLMENT AFTER TRANSITION PERIOD.—For limitations on termination of enrollment under this title on or after January 1, 1997, see section 2204(c).

"SEC. 2204. REQUIREMENT OF HEALTH INSURANCE COVERAGE.

''(a) REQUIREMENT FOR ALL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—Effective on and after the date specified in subsection (e), each eligible individual (as defined in section 2201(d)) who is not an excepted individual (as defined in paragraph (2)), is deemed to have enrolled under this title on the date before such date or as soon thereafter as the individual is not an excepted individual. If such an individual has not filed an application for enrollment under this title by such date, the Secretary shall provide a

means to collect information sufficient to effect such enrollment as soon as possible after such date.

''(2) EXCEPTED INDIVIDUALS.—For purposes of paragraph (1), the term 'excepted individual' means an individual who—

''(A) is a medicare beneficiary,

''(B) is enrolled under a qualified employer health plan, or

''(C) demonstrates (in a manner specified by the Secretary) enrollment under a Federal health plan (as defined in subsection (f)).

''(b) AUTOMATIC CONTINUING ENROLLMENT.—For provisions relating to coordination of enrollment among qualified health plans and assuring continuous coverage for required health services (and portability of health insurance benefits among such plans), see section 2157.

''(c) LIMITATION ON TERMINATION OF ENROLLMENT.—Effective on the date specified in subsection (e)—

''(1) EMPLOYMENT-BASED ENROLLMENT.—An individual enrolled under this title on an employment basis may not elect to terminate such enrollment.

''(2) NON-EMPLOYMENT BASIS.—An individual enrolled under this title on a non-employment basis may not terminate such enrollment unless—

''(A) the individual is no longer eligible to be enrolled under this title because of a change of immigration or residency status, or

''(B) the individual demonstrates to the satisfaction of the Secretary that the individual is a medicare beneficiary or is enrolled under a qualified employer health plan.

''(d) ENFORCEMENT.—

''(1) MONITORING OF INDIVIDUAL TAX RETURNS.—The Secretary of the Treasury shall require the filing of such information as may be necessary to establish compliance with subsection (a).

''(2) RETROACTIVE ENROLLMENT.—If such an individual has not provided evidence of enrollment in a qualified employer health plan or Federal health plan, the Secretary—

''(A) shall enroll the individual pursuant to the filing of such return, and

''(B) shall require the payment of twice the amounts of premiums that would have been paid if the person had been enrolled on a timely basis, unless the individual has established to the satisfaction of the Secretary good cause for the failure to enroll on a timely basis.

''(e) EFFECTIVE DATE OF REQUIREMENT.—The date specified in this subsection is January 1, 1997.

''(f) FEDERAL HEALTH PLAN DEFINED.—In this section, the term 'Federal health plan' means a health plan of, or contributed to by, the Federal Government on behalf of its employees, retirees, and their family members, and includes—

''(1) the Federal employees health insurance program under chapter 89 of title 5, United States Code,

''(2) the program for the provision of medical and dental benefits under chapter 55 of title 10, United States Code, and

''(3) the program for the provision of hospital care and medical services by the Department of Veterans' Affairs under chapter 17 of title 38, United States Code.

''PART B—HEALTH INSURANCE BENEFITS

"SEC. 2211. REQUIRED HEALTH SERVICES.

''(a) MEDICARE BENEFITS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this part and part C, the health insurance benefits provided to an individual enrolled under this title (whether on an employment basis or a non-employment basis) shall consist of en-

titlement to the same benefits as are provided under title XVIII to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

''(2) REQUIRED HEALTH SERVICES DEFINED.—In this title and title XXI, the term 'required health services' means the services provided under this title (including services described in subsections (b) and (c)).

''(b) UNLIMITED INPATIENT HOSPITAL SERVICES FOR CHILDREN.—For children, required health benefits also shall include payment for inpatient hospital services without regard to any day limitations under subsections (a)(1) and (b)(1) of section 1812.

''(c) PREGNANCY-RELATED SERVICES.—

''(1) IN GENERAL.—In the case of a pregnant woman (as defined in section 2283(3)), benefits under this title shall include entitlement to have payment made for the following, subject to the periodicity schedule established with respect to the services under paragraph (2) and prior authorization of certain services under paragraph (3):

''(A) Prenatal care, including care for all complications of pregnancy.

''(B) Inpatient labor and delivery services.

''(C) Postnatal care.

''(D) Postnatal family planning services.

''(2) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in paragraph (1) should be provided to pregnant women without complications of pregnancy.

''(3) PRIOR AUTHORIZATION REQUIRED FOR CERTAIN SERVICES.—

''(A) IN GENERAL.—Except in the case of items and services specified under subparagraph (B), benefits are not available with respect to an item or service under paragraph (1) unless the provision of the item or service has been approved by a utilization and quality control peer review organization before the provision of the item or service.

''(B) EXCEPTION FOR ROUTINE OR COMMON ITEMS AND SERVICES.—Subparagraph (A) shall not apply to items and services which the Secretary has specified on a list as being either—

''(i) related to normal pregnancy, or

''(ii) related to a highly prevalent complication of pregnancy,

or in the case of emergency services.

''(d) PREVENTIVE SERVICES DEFINED.—In this title, the term 'preventive services' means the following items and services furnished in accordance with any applicable periodicity schedules:

''(1) Pregnancy-related services (described in subsection (c)(1)).

''(2) Well-child care (as defined in section 1861(ll)(1)).

''(3) Screening mammography (as defined in section 1861(jj)).

''(4) Screening pap smear (as defined in section 1861(nn)).

''(5) Colorectal cancer screening services.

''(6) Immunization services described in section 1862(a)(1)(H).

The services referred to in paragraph (5) are screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer.

''PART C—PAYMENTS FOR BENEFITS; DEDUCTIBLES, COINSURANCE, AND STOP-LOSS PROTECTION FOR REQUIRED HEALTH SERVICES

"SEC. 2221. PAYMENTS FOR BENEFITS.

''(a) USE OF MEDICARE PAYMENT RULES.—

''(1) IN GENERAL.—Except as otherwise provided in this title—

''(A) payment of benefits under this title with respect to services shall be made, subject to adjustment in payment rates under subsection (b), in the same amounts and on the same basis as payment may be made with respect to such services under title XVIII, and

''(B) the provisions of sections 1814, 1815, 1833, 1834, 1835, 1842, 1848, 1886, 1887 shall apply to payment of benefits (and provision of services and charges thereon) under this title in the same manner as they apply to benefits, services, and charges under title XVIII.

''(2) IDENTIFICATION OF COMPARABLE PAYMENT METHODS FOR NEW SERVICES.—In the case of services for which there is not a payment basis established under title XVIII, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title.

''(3) NO JUDICIAL OR ADMINISTRATION REVIEW.—There shall be no administrative or judicial review of the payment rates or rules under this section (including adjustments made under subsection (b)).

''(b) PAYMENT BASED ON APPROVED RATES.—

''(1) IN GENERAL.—Payments for services under this title shall be based on rates approved by the Federal Health Care Cost Containment Commission under title III of the Health Insurance Coverage and Cost Containment Act of 1993.

''(2) PAYMENT FOR OBSTETRICAL SERVICES.—

''(A) GLOBAL FEE.—In making payment under this title with respect to the group of obstetrical services typical of treatment throughout a course of pregnancy, the Secretary shall establish a global fee schedule with respect to such group of services.

''(B) DISINCENTIVE FOR CESAREAN SECTIONS.—The fee schedule amount otherwise established with respect to a cesarean section shall be 95 percent of the fee schedule amount otherwise established.

''(c) USE OF TRUST FUND.—In applying the provisions described in subsection (a)(1)(B) in carrying out this

section, any reference in title XVIII to a trust fund shall be treated as a reference to the Public Health Trust Fund established under section 2233.

''(d) WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICARE AND MEDICAID PROVIDERS.—The provisions of section 1885 (relating to withholding of payments for certain medicaid providers) shall apply under this title in the same manner as they apply under title XVIII, except that for this purpose any reference in such section to title XIX shall be deemed to include a reference to title XVIII.

''SEC. 2222. DEDUCTIBLE FOR REQUIRED HEALTH SERVICES.

''(a) DEDUCTIBLE.—

''(1) IN GENERAL.—Except as provided in this section and part E, the amount of expenses for required health services with respect to which an individual is entitled to have payment made under this title for any year shall first be reduced by a deductible of $250.

''(2) FAMILY LIMIT OF $500.—In the case of a family, the deductible under paragraph (1) shall not apply in a year after members of the family (who are not medicare beneficiaries) have collectively had expended $500 towards such deductible.

''(3) APPLICATION OF DEDUCTIBLE IN PLACE OF MEDICARE DEDUCTIBLES.—Under this title, the deductible established under this subsection shall be applied instead of applying the deductible for inpatient hospital services under the first sentence of section 1813(a)(1) and the deductible under section 1833(b).

''(4) INDEXING OF DOLLAR AMOUNTS OF DEDUCTIBLE.—The dollar amounts specified in paragraphs (1) and (2) shall each be increased each year (beginning with second year after the year in which this title is enacted) by a percentage equal to the percentage increase in the contribution and benefit base (determined under section 230) from the year before the year in which this title is enacted to the year before the year involved. Any such increase shall be rounded to the nearest multiple of $5.

''(b) DEDUCTIBLE DOES NOT APPLY TO PREVENTIVE SERVICES.—The deductible established under subsection (a) does not apply to preventive services provided consistent with any applicable periodicity schedules.

"SEC. 2223. COINSURANCE FOR REQUIRED HEALTH SERVICES.

''(a) COINSURANCE RATES.—Subject to subsections (b) and (c) and part E, the coinsurance rates applicable

to required health services under title XVIII shall apply in the administration of this title.

''(b) NO COINSURANCE FOR PREVENTIVE SERVICES.—There shall be no coinsurance under this title in the case of preventive services provided consistent with any applicable periodicity schedules.

''(c) NO COINSURANCE FOR INPATIENT HOSPITAL SERVICES FOR CHILDREN.—There shall be no coinsurance under this title in the case of inpatient hospital services furnished to children.

''SEC. 2224. LIMIT ON COST-SHARING FOR REQUIRED HEALTH SERVICES.

''(a) LIMITATION.—

''(1) IN GENERAL.—Whenever in a calendar year an individual's or family's expenses for the deductible and coinsurance with respect to required health services covered under this title and furnished during the year equals $2,500 or $3,000, respectively, payment of benefits under this title for the individual or family for required health services furnished during the remainder of the year shall be paid without the application of any coinsurance.

''(2) INDEXING OF DOLLAR AMOUNT OF LIMIT.—The dollar amounts specified in paragraph (1) shall be increased each year (beginning with the

second year after the year in which this title is enacted) by a percentage equal to the percentage increase in the contribution and benefit base (determined under section 230) from the year before the year in which this title is enacted to the year before the year involved. Any such increase shall be rounded to the nearest multiple of $5.

''(b) CREDITING FOR EXPENSES INCURRED UNDER QUALIFIED EMPLOYER HEALTH PLANS.—Cost sharing incurred under a qualified employer health plan for required health services shall be credited under this section against the limits contained in subsection (a).

"SEC. 2225. EXCLUSIONS; COORDINATION.

''(a) EXCLUSIONS.—

''(1) IN GENERAL.—Except as provided in this section, section 1862 shall apply to expenses incurred for items and services provided under this title the same manner as such section applies to items and services provided under title XVIII.

''(2) PREVENTIVE SERVICES.—In the case of preventive services provided consistent with the applicable periodicity schedule—

''(A) such services shall be considered to be reasonable and medically necessary, and

''(B) shall not be subject to exclusion through the operation of paragraph (1), (7), or (12) of section 1862(a) (as incorporated under paragraph (1)).

''(3) USE OF SAME NATIONAL COVERAGE DECISION REVIEW PROCESS.—The provisions of section 1869(b)(3) shall apply under this title in the same manner as they apply under title XVIII. Any determination under such title that, under paragraph (1), would apply under this title shall not be subject to review under this paragraph.

''(b) RELATIONSHIP TO MEDICARE IN CASE OF EMPLOYMENT-BASED ENROLLMENT.—In the case of enrollment of a medicare beneficiary on an employment basis under this title, in applying section 1862(b) (pursuant to subsection (a)(2) of this section), the public health plan shall be treated as a large group health plan (described in section 1862(b)).

''SEC. 2226. APPLICATION OF PARTICULAR QUALIFIED HEALTH PLAN REQUIREMENTS.

''Section 2152 (relating treatment of family members as a unit; coverage period; and health plan cards) and section 2157 (relating to coordination and portability of health coverage under qualified health plans) shall apply

to the public health plan in the same manner as they apply to a qualified health plan.

''PART D—PREMIUMS, PUBLIC HEALTH TRUST FUND

"SEC. 2231. PREMIUMS.

''(a) AMOUNT OF PREMIUMS.—

''(1) IN GENERAL.—Except as provided in this section (and section 2234 with respect to nonenrolling employer premiums), the premium to be charged for enrollment under this title of any individual in a beneficiary class (as defined in subsection (d)) in any community (as defined in subsection (e)) is the actuarial rate established under paragraph (2) with respect to such class and community.

''(2) CREDIT FOR EMPLOYMENT TAXES PAID FOR PART-TIME AND SEASONAL OR TEMPORARY EMPLOYEES.—

''(A) IN GENERAL.—Subject to subparagraph (C), in the case of an individual who is a covered employee (as defined in subparagraph (B)), the premium to be charged for enrollment under this title on a non-employment basis is—

''(i) the actuarial rate otherwise applicable under paragraph (1), less the amount of the taxes paid by the individual and all

employers with respect to the employee (and family members of the employee) under section 3151(a) of the Internal Revenue Code of 1986, or

''(ii) 20 percent of such actuarial rate,

whichever is greater.

''(B) COVERED EMPLOYEE DEFINED.—In subparagraph (A), the term 'covered employee' means an individual—

''(i) who is employed by one or more employers as a part-time employee or as a seasonal or temporary employee, and

''(ii) none of whose employers is enrolling part-time employees or seasonal or temporary employees, respectively, under a qualified employer health plan, but all of which are required to pay a tax with respect to such employees under section 3151(a)(1) of the Internal Revenue Code of 1986,

and includes the family members of such an employee.

''(C) LIMIT ON PREMIUM WHERE PREMIUM SUBSIDY.—In no case shall the premium under subparagraph (A) exceed—

''(i) the beneficiary actuarial rate otherwise applicable under paragraph (1), reduced by

''(ii) the amount of any premium subsidy under part E.

''(b) DETERMINATION OF ACTUARIAL RATES.—

''(1) IN GENERAL.—In September of each year, beginning with 1993, the Secretary shall determine and publish the actuarial rate for each beneficiary class (as specified in subsection (d)) for each community (designated under subsection (e)) for health insurance benefits in the following year.

''(2) BASIS FOR ACTUARIAL RATES.—Each such actuarial rate shall be established in a manner so that if all eligible individuals in the class were enrolled under this title for the benefit package in the community, the aggregate of the rates would be equal to the total expenditures (including administrative expenses) with respect to that class and community under this title in that following year. Each such actuarial rate shall be uniform within each beneficiary class and community, and shall not vary among such individuals by age, sex, health, or other risk characteristics.

''(3) PUBLIC STATEMENT.—Whenever the Secretary publishes actuarial rates under this subsection, the Secretary shall, at the time of such publication, include a public statement setting forth the actuarial assumptions and bases employed in arriving at the amount of the actuarial rates.

''(c) NO JUDICIAL OR ADMINISTRATION REVIEW.—There shall be no administrative or judicial review of the actuarial rates determined under this section.

''(d) BENEFICIARY CLASSES.—For purposes of this section, the beneficiary classes are as follows:

''(1) 1 adult.

''(2) A married couple without children.

''(3) A married couple with 1 or more children, or 1 adult with 1 or more children.

''(e) COMMUNITY.—For purposes of this section, the term 'community' means a geographic area designated by the Secretary as—

''(1) encompassing one or more adjacent metropolitan statistical areas, or

''(2) the remaining area within each State (that is not designated within any community under paragraph (1));

except that the Secretary may designate an entire State as a community if such a designation would better carry

out the purposes of this title and title XXIII. The Secretary from time to time may change the boundaries of communities designated under paragraph (1) or (2) for such purposes. There shall be no administrative or judicial review of the designation of communities under this subsection.

''SEC. 2232. COLLECTION OF PREMIUMS.

''(a) INDIVIDUAL ENROLLMENT.—

''(1) IN GENERAL.—In the case of individuals enrolled on a non-employment basis under this title, the Secretary shall provide for the payment of premiums on a monthly or quarterly basis. To the maximum extent feasible, the Secretary shall arrange for payment of such premiums through automatic withholding from income sources or accounts with financial institutions. In the case of a part-time employee or seasonal or temporary worker, the amount of the premiums owed under this section shall be reduced by the amount of excise taxes paid under section 3151(a) of the Internal Revenue Code of 1986 with respect to such employment.

''(2) COLLECTION OF UNPAID PREMIUMS.—

''(A) TRANSMISSION OF INFORMATION TO SECRETARY OF THE TREASURY.—In the case of premium amounts owing and unpaid under this

subsection, the Secretary shall inform the Secretary of the Treasury of individuals or individuals owing such amounts and the amounts owed.

''(B) COLLECTION.—The Secretary of the Treasury shall assess and collect the amounts referred to in subparagraph (A) in the same manner as taxes imposed by subtitle C of the Internal Revenue Code of 1986.

''(b) NONENROLLING EMPLOYER PREMIUMS.—

''(1) EMPLOYER PREMIUMS.—In the case of an individual enrolled under this title on an employment basis, the employer shall provide for payment of premiums on a monthly or quarterly basis.

''(2) NONENROLLING EMPLOYER PREMIUMS.—In the case of nonenrolling employer premiums owed under section 2234, the Secretary shall require payment of premiums on a monthly or quarterly basis.

''(3) COLLECTION OF UNPAID PREMIUMS.—

''(A) TRANSMISSION OF INFORMATION TO SECRETARY OF THE TREASURY.—In the case of premium amounts owing and unpaid under this subsection, the Secretary shall inform the Secretary of the Treasury of the employers owing such amounts and the amounts owed.

''(B) COLLECTION.—The Secretary of the Treasury shall assess and collect the amounts referred to in subparagraph (A) in the same manner as taxes imposed by subtitle C of the Internal Revenue Code of 1986.

''(c) DEPOSIT.—Premiums collected under this section shall be deposited to the credit of the Public Health Trust Fund (established under section 2233).

"SEC. 2233. PUBLIC HEALTH TRUST FUND.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Public Health Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in paragraph (3) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part.

''(2) DEPOSIT OF TAXES.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the taxes imposed by—

''(A) part VIII of subchapter A of chapter 1 of the Internal Revenue Code of 1986, and

''(B) sections 3151, 5000A, and 5000B of such Code.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

''(3) AUTHORIZATION TO ACCEPT GIFTS.—The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund, or any activity financed through the Trust Fund.

''(b) INCORPORATION OF PROVISIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (j) of section 1817 shall apply to the Trust Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund.

''(2) EXCEPTIONS.—In applying paragraph (1)—

''(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

''(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund, to title XVIII (or part A thereof), or (in subsection (f)(1)) to section 3102(b) of the Internal Revenue Code of 1986 is deemed a reference to the Trust Fund under this section, this title, and to section 3151(a)(2) of such Code, respectively.

''(3) TRANSFERS TO HOSPITAL INSURANCE TRUST FUND.—There shall be transferred periodically (but not less often than monthly) from the Trust Fund to the Federal Hospital Insurance Trust Fund, amounts equivalent to the premium, deductible, and coinsurance subsidies provided under part E of this title with respect to premiums, deductibles, and coinsurance under part A of title XVIII.

''(4) TRANSFERS TO SMI TRUST FUND.—There shall be transferred periodically (but not less often than monthly) from the Trust Fund to the Federal

Supplementary Medical Insurance Trust Fund, amounts equivalent to the sum of—

''(A) to the premium, deductible, and coinsurance subsidies provided under part E of this title with respect to premiums, deductibles, and coinsurance under part B of title XVIII;

''(B) the net additional expenditures under part B of such title resulting from the amendments made by sections 501 through 504 and 507 of the Health Insurance Coverage and Cost Containment Act of 1993.

''SEC. 2234. TRANSFER PAYMENTS IN THE CASE OF MULTIPLE EMPLOYERS.

''(a) TREATMENT OF MULTIPLE EMPLOYMENT WHERE EMPLOYEE COVERED UNDER A QUALIFIED EMPLOYER HEALTH PLAN.—

''(1) IN GENERAL.—In the case of a multiple-employed individual (as defined in subsection (d)(1)) who is covered under a qualified employer health plan of an employer—

''(A) each nonenrolling employer (as defined in subsection (d)(2)) that offers coverage under a qualified employer health plan shall pay to the Public Insurance Trust Fund the

nonenrolling employer premium specified in subsection (b);

''(B) the enrolling employer is entitled to receive from such Trust Fund the enrolling employer subsidy specified in subsection (c); and

''(C) there will be no tax imposed on the wages of the individual under section 3151(a)(2) of the Internal Revenue Code of 1986 with respect to wages paid during the period of such coverage.

''(2) APPLICATION ON A MONTHLY BASIS.—The premiums and subsidies provided under this subsection shall be paid with respect to a monthly period of coverage.

''(b) AMOUNT OF NONENROLLING EMPLOYER PREMIUM.—

''(1) IN GENERAL.—The amount of the nonenrolling employer premium described in this subsection is the applicable percent of the actuarial rate (specified in section 2226(b)) for the beneficiary class in the community in which the employee is enrolled.

''(2) APPLICABLE PERCENT DEFINED.—For purposes of paragraph (1), the term 'applicable percent' means, with respect to an employee who is—

''(A) a full-time employee of the employer, 40 percent, or

''(B) a part-time employee of the employer, 20 percent.

''(c) AMOUNT OF ENROLLING EMPLOYER SUBSIDY.—

''(1) IN GENERAL.—The amount of the enrolling employer subsidy described in this subsection is the applicable percent of the actuarial rate (specified in section 2226(b)) for the beneficiary class in the community in which the employee is enrolled.

''(2) APPLICABLE PERCENT DEFINED.—For purposes of paragraph (1), the term 'applicable percent' means, with respect to a multiple-employee who (or whose spouse) is—

''(A) a full-time employee of a nonenrolling employer, 40 percent, or

''(B) not a full-time employee of a nonenrolling employer, but is a part-time employee of a nonenrolling employer, 20 percent.

In no case shall the applicable percent with respect to a multiple-employed employee (including the employee's spouse) exceed 40 percent.

''(d) DEFINITIONS.—In this section:

''(1) MULTIPLE-EMPLOYED INDIVIDUAL.—The term 'multiple-employed individual' means an individual who in a month is an employee (whether part-time or full-time) and—

''(A) who is also employed (whether part-time or full-time) by 1 or more other employer, or

''(B) whose spouse or parent is also an employee (whether part-time or full-time) of 1 or more employers.

''(2) NONENROLLING EMPLOYER.—The term 'nonenrolling employer' means, with respect to a multiple-employed individual who is enrolled under a qualified employer health plan of an employer, any employer of such individual other than such employer.

"SEC. 2235. USE OF UNIFORM CLAIMS FORMS; UNIFORM INFORMATION REPORTING.

''The Secretary shall provide for—

''(1) submission of claims under this title (and title XVIII) in accordance with section 323 of the Health Insurance Coverage and Cost Containment Act of 1993, and

''(2) reporting to the Commission of information on required health services provided under this

title (or title XVIII) pursuant to standards promulgated under section 324 of such Act.

''PART E—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

"SEC. 2241. ASSISTANCE FOR INDIVIDUALS WITH INCOME BELOW THE POVERTY LINE ENROLLED ON A NON-EMPLOYMENT BASIS.

''In the case of an individual—

''(1) who is enrolled under this title on a non-employment basis,

''(2) who is not a medicare beneficiary, and

''(3) whose family adjusted total income (as defined in section 2247) does not exceed 100 percent of the official poverty line (as defined in section 2283(2)),

the low-income assistance under this part shall consist of waiver of the premiums imposed under section 2231(a) and of any deductibles or coinsurance under this title for the individual and the individual's family.

"SEC. 2242. ASSISTANCE FOR INDIVIDUALS WITH INCOME BELOW TWICE THE POVERTY LINE ENROLLED ON A NON-EMPLOYMENT BASIS.

''(a) NON-MEDICARE POPULATION.—In the case of an individual who is not a medicare beneficiary, who is enrolled under this title on a non-employment basis, and whose family adjusted total income exceeds 100 percent

but is less than 200 percent, of the official poverty line, the low-income assistance under this part shall consist of the following:

''(1) PREMIUMS.—The premium amount under section 2231(a) shall be reduced by the subsidy percentage (as defined in subsection (b)) of the premium amount otherwise applied. Any reduction in premium under this paragraph shall be rounded to the nearest multiple of $5.

''(2) DEDUCTIBLE.—The deductibles under section 2222 shall be reduced by the subsidy percentage of the deductibles otherwise applied. Any reduction in a deductible under this paragraph shall be rounded to the nearest multiple of $10.

''(3) COINSURANCE.—The percentage coinsurance applied under section 2223 shall be reduced by the subsidy percentage multiplied by the percentage coinsurance otherwise applied.

''(b) SUBSIDY PERCENTAGE DEFINED.—

''(1) IN GENERAL.—In this section and section 2243, the term 'subsidy percentage' means the number of percentage points by which the family's adjusted total income (expressed as a percent of the applicable official poverty line) is less than 200 percent.

''(2) ROUNDING FOR COINSURANCE.—For purposes of subsection (a)(3), the subsidy percentage (as applied to the coinsurance percentage) shall be rounded to the nearest multiple of 5 percent.

"SEC. 2243. ASSISTANCE FOR INDIVIDUALS COVERED UNDER QUALIFIED EMPLOYER HEALTH PLANS.

''(a) IN GENERAL.—In the case of an eligible individual who is enrolled under a qualified employer health plan or is enrolled under this title on an employment basis, low-income assistance under this part shall consist of—

''(1) payment (in a manner specified by the Secretary) of the amount of the premium subsidy under subsection (b) to the individual or another family member, or, in the case described in subsection (b)(4), the employer, and

''(2) payment to the plan of the amount of the deductible and coinsurance subsidy under subsection (c).

Such subsidies shall apply to premiums, deductibles, and coinsurance for the individual and family member covered on an employment basis under the plan or under this title.

''(b) PREMIUM SUBSIDY.—In the case of an eligible individual who is enrolled under a qualified employer health plan—

''(1) TREATMENT UNDER QUALIFIED EMPLOYER HEALTH PLAN.—

''(A) AMOUNT.—The amount of the premium subsidy under this subsection is the subsidy percentage (as defined in section 2242(c)) of the employee share of the premium. Any premium subsidy under this paragraph which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(B) USE OF LEAST EXPENSIVE QUALIFIED PLAN.—In applying subparagraph (A), the amount of the premium subsidy shall be based on the qualified employer health plan available to the employee with the smallest premium payment required of the employee (for the type of individual or family enrollment with which the employee is enrolled).

''(C) FREQUENCY OF PAYMENT.—Except as provided in subparagraph (D), the premium subsidy under this subsection shall be paid not less frequently than quarterly or, if the amount of the premium subsidy on a monthly basis exceeds $20, monthly.

''(D) OPTIONAL, DIRECT COORDINATION WITH EMPLOYERS.—In the case of an employee—

''(i) who is enrolled under a covered employer health plan,

''(ii) who is entitled to assistance under this part,

''(iii) whose employer agrees to enter into an arrangement with the Secretary under this subparagraph, and

''(iv) who assigns (in the manner specified by the Secretary) rights to premium subsidies under this paragraph to the employer,

the Secretary shall enter into an arrangement with the employer under which (I) the employer agrees to reduce premiums otherwise imposed with respect to the individual by the amount of the subsidy, and (II) the Secretary agrees to make payment (not less often than monthly) to the employer of the amount of such premium subsidy.

''(2) TREATMENT UNDER PUBLIC HEALTH PLAN.—In the case of an eligible individual who is enrolled on an employment basis under this title—

''(A) AMOUNT.—The amount of the premium subsidy under this subsection is the subsidy percentage (as defined in section 2242(c)) of the taxes paid under section 3151(a)(2) of the Internal Revenue Code of 1986.

''(B) FREQUENCY OF PAYMENT.—The premium subsidy under this subsection shall be paid not less frequently than quarterly or, if the amount of the premium subsidy on a monthly basis exceeds $20, monthly.

''(c) DEDUCTIBLE AND COINSURANCE SUBSIDY.—

''(1) DEDUCTIBLE SUBSIDY AMOUNT.—The amount of the deductible subsidy under this subsection is the subsidy percentage of the deductible otherwise applied. Any deductible subsidy under this paragraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(2) COINSURANCE SUBSIDY AMOUNT.—The amount of the coinsurance subsidy under this subsection is the product of the subsidy percentage, the percentage coinsurance otherwise applied, and the payment amount permitted for required health services.

''(3) DIRECT COORDINATION BY QUALIFIED EMPLOYER HEALTH PLAN REQUIRED.—In the case of

an individual enrolled under a qualified employer health plan, the plan shall provide for—

''(A) acceptance of information, electronically, from the Secretary on the amount of the deductible and coinsurance subsidy for individuals (and family members),

''(B) a reduction in the deductibles and coinsurance otherwise imposed to reflect the deductible and coinsurance subsidies to which the individual and family members are entitled,

''(C) reasonably prompt payment of bills for which such charges have been made, and

''(D) transmission of such information as is necessary to indicate the amount of subsidy provided under the plan for specified individuals.

In return, the Secretary shall provide for payment, not less often than monthly, to the plan of the amount of payments made by such a plan for deductible and coinsurance subsidies under this subsection.

''SEC. 2244. APPLICATIONS FOR ASSISTANCE.

''(a) IN GENERAL.—Subject to section 2245, any individual who seeks assistance under this part (with respect to himself or herself or a family member) shall submit a

written application, by person or mail, to the Secretary. The application may be submitted with an application to enroll under this title or separately.

''(b) BASIS FOR DETERMINATION.—Subject to section 2245 and reconciliation under such section, eligibility for assistance under this part shall be based on 4 times the family adjusted total income (as defined in section 2247) during the 3 months preceding the month in which the application is filed.

''(c) FORM AND CONTENTS.—An application for assistance under this part shall be in a form and manner specified by the Secretary and shall require—

''(1) the provision of information necessary to make the determinations described in subsection (b),

''(2) the provision of information respecting any covered employer health plan in which the individual is enrolled, and

''(3) the individual (if enrolled under such a plan) to assign rights for deductible subsidies under this part to such plan.

Such form also shall include an option to execute, as part of completing the form and in order to meet the condition described in section 2243(b)(4)(D), an assignment of an individual's right for premium subsidies under this part to an employer.

''(d) FREQUENCY OF APPLICATIONS.—

''(1) IN GENERAL.—An application for assistance under this part may be filed at any time during the year and may be resubmitted (but, except as provided in paragraph (3), not more frequently than once every 3 months) based upon a change of income or family composition.

''(2) NEED TO REAPPLY.—In the case of an individual who—

''(A) is entitled to assistance under this section in September of a year, and

''(B) wishes to remain eligible for benefits for months beginning with January of the following year,

the individual (or a family member) must file with the Secretary in October of that preceding year a new application for assistance. If an individual fails to file a new application under this paragraph, an application for such assistance with respect to any family member may not be filed during November or December of that preceding year.

''(3) CORRECTION OF INCOME.—Nothing in paragraph (1) shall be construed as preventing an individual or family from, at any time, submitting an application to reduce the amount of assistance under

this part based upon an increase in income from that stated in the previous application.

''(e) TIMING OF ASSISTANCE.—

''(1) IN GENERAL.—If an application for assistance under this part is filed—

''(A) on or before the 15th day of a month, assistance under this part shall be available for premiums for months after such month and, with respect to the deductible, for expenses incurred after such month; or

''(B) after the 15th day of a month, assistance under this part shall be available for premiums for months after the month following such month and, with respect to the deductible, for expenses incurred after such following month.

''(2) WELFARE RECIPIENTS.—In the case of an individual or family with respect to whom an application for assistance is not required because of section 2246, in applying paragraph (1), the date of approval of aid or benefits described in such section shall be considered the date of filing of an application for assistance under this part.

''(f) VERIFICATION.—The Secretary shall provide for verification, on a sample basis or other basis, of the infor-

mation supplied in applications under this part. This verification shall be separate from the reconciliation provided under section 2245.

''(g) HELP IN COMPLETING APPLICATIONS.—The Secretary shall provide, from funds appropriated to carry out this title, for grants to public or private nonprofit entities that will make available assistance to individuals and families in filing applications for assistance under this part. The Secretary shall make grants in a manner that provides such assistance at a variety of sites (such as low-income housing projects and shelters for homeless individuals) that are readily accessible to individuals and families eligible for assistance under this part.

''(h) PENALTIES FOR INACCURATE INFORMATION.—

''(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application for assistance under this part or otherwise makes a material misrepresentation of information in such an application shall be liable to the Federal Government for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Secretary.

''(2) PENALTIES FOR MISREPRESENTATION.—Each individual who knowingly misrepresents mate-

rial information in an application for assistance under this part shall be liable to the Federal Government for $1,000 or, if greater, three times the excess payments made based on such misrepresentation.

''(i) FILING OF APPLICATION DEFINED.—Except as provided in subsection (e)(2), for purposes of this part, an application under this part is considered to be 'filed' on the date on which the complete application, including all documentation required to act on the application, has been filed with the Secretary.

"SEC. 2245. RECONCILIATION OF PREMIUM ASSISTANCE THROUGH USE OF INCOME STATEMENTS.

''(a) REQUIREMENT FOR FILING OF INCOME STATEMENT.—Subject to section 2246, in the case of a family which is receiving low-income assistance under this part for any month in a year, a member of the family shall file with the Secretary, by not later than April 15 of the following year, a statement that verifies the family's total adjusted family income for the taxable year ending during the previous year. Such a statement shall provide information necessary to determine the family adjusted total income during the year and the number of family members in the family as of the last day of the year.

''(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the statement filed under subsection (a) with respect to a family or individual, subject to section 2246, the Secretary shall compute the amount of assistance that should have been provided under this part with respect to premiums for the family in the year involved. If the amount of such assistance computed is—

''(1) greater than the amount of premium assistance provided, the Secretary shall provide for payment (directly or through a credit against future premiums owed) to the family or individual involved of an amount equal to the amount of the deficit, or

''(2) less than the amount of assistance provided, the Secretary shall require the family or individual to pay (directly or through an increase in future premiums owed) to the Secretary (to the credit of the program under this title) an amount equal to the amount of the excess payment.

''(c) DISQUALIFICATION FOR FAILURE TO FILE.—Subject to section 2246, in the case of any family that is required to file an information statement under subsection (a) in a year and that fails to file such a statement by the deadline specified in such subsection, no member of the family shall be eligible for assistance under this part

after May 1 of such year. The Secretary shall waive the application of this subsection if the family establishes, to the satisfaction of the Secretary, good cause for the failure to file the statement on a timely basis.

''(d) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to a criminal penalty to the same extent as a criminal penalty may be imposed under section 1128B(a) with respect to a person described in clause (ii) of such section.

''(e) NOTICE OF REQUIREMENT.—The Secretary shall provide for written notice, in March of each year, of the requirement of subsection (a) to each family which received assistance under this part in any month during the preceding year and to which such requirement applies.

''(f) TRANSMITTAL OF INFORMATION.—The Secretary of the Treasury shall transmit annually to the Secretary such information relating to the adjusted total income of individuals for the taxable year ending in the previous year as may be necessary to verify the reconciliation of assistance under this section.

''(g) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of assistance provided with respect to deductibles and coinsurance.

"SEC. 2246. TREATMENT OF CERTAIN CASH ASSISTANCE RECIPIENTS.

''In the case of a family that has been determined to be eligible for aid under part A or E of title IV or an individual who has been determined to be eligible for supplemental security income benefits under title XVI—

''(1) the family or individual is deemed, without the need to file an application for assistance under section 2244, to have adjusted total income below 100 percent of the official poverty line applicable to a family of the size involved,

''(2) the family or individual need not file a statement under section 2245(a), and

''(3) the assistance received by the family is not subject to reconciliation under section 2245(b).

"SEC. 2247. COMPUTATION OF FAMILY ADJUSTED TOTAL INCOME.

''In this part:

''(1) ADJUSTED TOTAL INCOME.—The term 'adjusted total income' means—

''(A) adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986), determined without the application of paragraphs (6) and (7) of such section and without the application of section 162(l) of such Code, plus

''(B) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income under section 86 of such Code.

''(2) FAMILY ADJUSTED TOTAL INCOME.—The term 'family adjusted total income' means, with respect to an individual, the sum of the adjusted total income for the individual and all the other family members.

''(3) FAMILY SIZE.—The family size to be applied under this part, with respect to family adjusted total income, is the number of individuals included in the family for purposes of coverage of health insurance benefits under this title or under a qualified employer health plan (as the case may be).

''PART F—ADMINISTRATIVE PROVISIONS

"SEC. 2261. AGREEMENTS WITH HOSPITALS; PARTICIPATING PHYSICIANS; TREATMENT OF INDIAN HEALTH SERVICE FACILITIES.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—Any hospital shall be qualified to participate under this title and shall be eligible for payments under this title if—

''(A) it has in effect a participation agreement under section 1866(a)(1), and

''(B) it files with the Secretary a participation agreement meeting the requirements of subsection (b).

''(b) ELEMENTS OF AGREEMENT.—

''(1) IN GENERAL.—Except as provided in this subsection, a participation agreement under this subsection shall provide terms, specified by the Secretary, that are the same terms as those required of hospital participation agreements under section 1866(a)(1).

''(2) MODIFIED COPAYMENTS.—Instead of the limitation on charges specified under paragraphs (1)(A) and (2) of section 1866(a), the agreement shall not permit the hospital to charge more than the applicable deductible and coinsurance permitted under this title.

''(3) ACCEPTANCE OF PAYMENT LIMITS.—Each agreement shall require the hospital not to impose charges that exceed the payment rates approved under title III of the Health Insurance Coverage and Cost Containment Act of 1993. The previous sentence shall not be construed as prohibiting a qualified employer health plan from negotiating or otherwise providing payment rates that are less than such reference rates.

''(c) PHYSICIAN PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—Except as provided in this subsection, the Secretary shall provide for participating physician agreements under this title in the same manner as such agreements are provided for under title part B of title XVIII pursuant to section 1842(h).

''(2) LIMITATION ON CHARGES TO OTHER ENTITIES.—A participating physician agreement under this subsection shall provide that the physician agrees not to impose charges with respect to required health services that exceed the payment rates approved with respect to such services under title III of the Health Insurance Coverage and Cost Containment Act of 1993. The previous sentence shall not be construed as prohibiting a qualified employer health plan from negotiating or otherwise providing payment rates that are less than such reference rates.

''(d) INDIAN HEALTH SERVICE FACILITIES.—The provisions of section 1880 (relating to Indian health service facilities) shall apply to this title in the same manner as they apply under title XVIII.

"SEC. 2262. HEALTH MAINTENANCE ORGANIZATIONS.

''(a) IN GENERAL.—Except as provided in this section, section 1876 shall apply to individuals entitled to benefits under this title in the same manner as such section applies to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

''(b) APPLICATION.—In applying section 1876 under this section—

''(1) the provisions of such section relating only to individuals enrolled under part B of title XVIII shall not apply;

''(2) any reference to a Trust Fund established under title XVIII and to benefits with respect to any services under such title is deemed a reference to the Public Health Trust Fund and to health insurance benefits with respect to required health services under this title;

''(3) the adjusted average per capita cost shall be determined on the basis of benefits under this title;

''(4) subsections (f) and (h) shall not apply; and

''(5) in applying subsection (c)(3)(B), an eligible organization may require a minimum period of enrollment (of not greater than 6 months) during which an individual may not disenroll other than for

cause or unless enrollment under this title is terminated.

"SEC. 2263. USE OF FISCAL AGENTS.

''(a) USE OF FISCAL AGENTS.—

''(1) IN GENERAL.—Except as provided in this section, the Secretary shall provide for the administration of this title through the use of fiscal agents in the same manner as title XVIII is carried out through the use of such fiscal intermediaries and carriers.

''(2) SPECIAL RULES.—In the administration of this title, the Secretary—

''(A) may use a single carrier with respect to all required health services in an area, and

''(B) shall establish performance standards at least as rigorous as the performance standards applied in the administration of title XVIII.

''(3) SEPARATE CONTRACTS.—Contracts with fiscal agents entered into pursuant to this subsection for an area need not be with the same fiscal intermediary or carrier with an agreement under section 1816 or a contract under section 1842 for the area. However, nothing in this section shall be construed as preventing such an organization with

such an agreement or contract under such section from entering into a contract under this section.

''(b) REQUIRING USE OF ELECTRONIC BILLING.—Effective for claims submitted on or after January 1, 1997, payment shall only be made under this title on the basis of bills or charges that are submitted electronically in a manner specified by the Secretary.

"SEC. 2264. GENERAL ADMINISTRATION.

''(a) THROUGH HEALTH CARE FINANCING ADMINISTRATION.—Except as otherwise provided in this title, this title shall be administered by the Health Care Financing Administration.

''(b) REGULATIONS; TITLE II PROVISIONS; ADMINISTRATION.—The provisions of sections 1871, 1872, and 1874 (relating to regulations, application of certain provisions of title II, and administration) shall apply to this title in the same manner as they apply to title XVIII.

''(c) TREATMENT OF AMOUNTS DUE.—In bankruptcy and reorganization proceedings, amounts owed to the public health plan under this title shall be treated in the same manner as amounts owed to the Federal Government under the Federal Insurance Contributions Act.

"SEC. 2265. DETERMINATIONS; APPEALS; PROVIDER REIMBURSEMENT REVIEW BOARD.

''(a) DETERMINATIONS.—The determination of whether an individual is entitled to benefits under this title and the determination of the amount of benefits under this title shall be made by the Secretary in accordance with regulations prescribed by the Secretary.

''(b) HEARINGS.—

''(1) IN GENERAL.—Any individual dissatisfied with any determination under subsection (a) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Sections 206(a), 1102, and 1871 (as incorporated by reference by section 2264) shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes the individual, directly or indirectly, with services solely on the basis that the person furnishes the individual with such a service. Any person that furnishes services to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the

services involved in the appeal. If a person furnishes services to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.

''(2) LIMITATION.—Notwithstanding paragraph (1), a hearing shall not be available to an individual if the amount in controversy is less than $500 and judicial review shall not be available to the individual if the amount in controversy is less than $1,000. In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or involve related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.

''(3) EXPEDITED REVIEW.—In an administrative hearing pursuant to paragraph (1), where the moving party alleges that there are no material issues of fact in dispute, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.

''(c) PROVIDER REIMBURSEMENT REVIEW BOARD.—The provisions of section 1878 (relating to the Provider Reimbursement Review Board) shall apply under this title in the same manner as they apply under title XVIII.

"SEC. 2266. PROGRAM INTEGRITY; MISCELLANEOUS PROVISIONS.

''(a) PROGRAM INTEGRITY.—Sections 1124, 1124A, 1126, and 1128 through 1128B (relating to fraud and abuse) shall apply to this title in the same manner as they apply to title XVIII.

''(b) TITLE XI PROVISIONS.—The following provisions shall apply to this title in the same manner as they apply to title XVIII:

''(1) Section 1134 (relating to nonprofit hospital philanthropy).

''(2) Section 1138 (relating to hospital protocols for organ procurement and standards for organ procurement agencies).

''(c) WITHHOLDING OF PAYMENTS FROM CERTAIN PROVIDERS.—Subsections (a) through (c) of section 1885 shall apply to this title, the Secretary, and the Public Health Trust Fund in the same manner as such subsections apply to title XIX, the State agency, and the appropriate State agency paid funds under subsection (c), respectively.

"SEC. 2267. INFORMATION BY TELEPHONE.

''The Secretary shall provide information via a toll-free telephone number on the public health plan, including information concerning—

''(1) the requirement of section 2204, and

''(2) low-income assistance under part E.

"SEC. 2268. DEMONSTRATION PROJECT AUTHORITY.

''(a) DEMONSTRATION PROJECT AUTHORITY.—

''(1) IN GENERAL.—The Secretary is authorized to conduct demonstration projects—

''(A) to improve the delivery and quality of health care services under this title, and

''(B) to increase the efficiency and effectiveness of methods of payment for such services.

Subject to paragraph (2), the Secretary may waive such requirements of this title as may be necessary to carry out such demonstration projects.

''(2) LIMITATION.—The Secretary does not have the authority under paragraph (1)—

''(A) to reduce the benefits available under part B, or

''(B) to increase the deductibles or coinsurance under part C.

''(3) FUNDING.—Grants, payments under contracts, and other expenditures made for demonstration projects under this subsection—

''(A) shall be made from the Public Health Trust Fund,

''(B) may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and

''(C) shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection.

''(b) CONSTRUCTION.—Except as provided in subsection (a), the Secretary is not authorized to waive any requirement of this title.

"SEC. 2269. INCORPORATION OF MISCELLANEOUS MEDICARE PROVISIONS.

''(a) OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS.—The provisions of section 1870 (relating to overpayments on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals), other than subsection (b), shall apply under this title in the same manner as they apply under title XVIII.

''(b) LIMITATION ON CERTAIN PHYSICIAN REFERRALS.—The provisions of section 1877 (relating to limitation on certain physician referrals) shall apply under this title in the same manner as they apply under title XVIII.

''PART G—[RESERVED]

''PART H—DEFINITIONS AND MISCELLANEOUS

"SEC. 2281. INCORPORATION OF CERTAIN DEFINITIONS USED IN OTHER HEALTH-RELATED TITLES.

''(a) INCORPORATION OF MEDICARE DEFINITIONS.—In this title, the definitions contained in section 1861 apply for purposes of this title in the same manner as they apply for purposes of title XVIII.

''(b) INCORPORATION OF CERTAIN EMPLOYMENT-RELATED DEFINITIONS IN TITLE XXI.—In this title, except as otherwise provided, the definitions of the following terms contained in title XXI apply for purposes of this title:

''(1) COVERED EMPLOYER HEALTH PLAN.—The term 'covered employer health plan' as defined in section 2121(b).

''(2) EMPLOYEE.—The term 'employee' as defined in section 2181(a)(3).

''(3) FULL-TIME EMPLOYEE.—The term 'full-time employee' as defined in section 2181(b)(1).

''(4) LARGE EMPLOYER.—The term 'large employer' as defined in section 2181(c)(3).

''(5) MEDIUM-SIZE EMPLOYER.—The term 'medium-size employer' as defined in section 2181(c)(2).

''(6) PART-TIME EMPLOYEE.—The term 'part-time employee' as defined in section 2181(b)(2).

''(7) QUALIFIED EMPLOYER HEALTH PLAN.—The term 'qualified employer health plan' as defined in section 2121(a).

''(8) SEASONAL OR TEMPORARY EMPLOYEE.—The term 'seasonal or temporary employee' as defined in section 2181(b)(3).

''(9) SMALL EMPLOYER.—The term 'small employer' as defined in section 2181(c)(1).

''(10) VERY LARGE EMPLOYER.—The term 'very large employer' as defined in section 2181(c)(4).

''(11) WAGES.—The term 'wages' as defined in section 2181(a)(1).

"SEC. 2282. DEFINITIONS RELATING TO FAMILIES.

''In this title:

''(1) IN GENERAL.—Except as provided in paragraph (2), the terms 'family' and 'family member' mean an individual and the individual's spouse, and includes all the individual's children.

''(2) TREATMENT OF FAMILIES WITH MEDICARE BENEFICIARIES FOR COVERAGE PURPOSES.—In the case of a family with a medicare beneficiary, if coverage is provided to family members other than on the basis of employment of a family member, the beneficiary shall not be treated under this title as a member of the family for purposes of determining eligibility for coverage but shall be treated as a separate individual. However, except as provided in section 2242(b)(2), for purposes of applying part E, a medicare beneficiary shall continue to be treated as a member of the beneficiary's family.

''(3) SPOUSE.—The term 'spouse' means, with respect to an individual, the individual to which the individual is married.

''(4) MARRIED; UNMARRIED.—Marital status shall be determined in accordance with section 7703 of the Internal Revenue Code of 1986.

''(5) CHILD.—The term 'child' means, with respect to a person who is not a child, an individual—

''(A) who (i) is unmarried and under 18 years of age, (ii) is unmarried and under 23 years of age and a full-time student, or (iii) is an unmarried, dependent child, regardless of age, who is incapable of self-support because of

mental or physical disability which existed before age 22;

''(B)(i) who is the child of the person or the person's spouse, or

''(ii) who is the legal ward of the person or the person's spouse; and

''(C) who is not in the legal custody of another individual.

The Secretary shall establish, by regulation, such rules as are appropriate with respect to the treatment of foster children, emancipated minors, children in the process of adoption, and other unmarried individuals under 23 years of age under similar circumstances as children for purposes of this title.

''(6) ADULT.—The term 'adult' means an individual who is not a child.

"SEC. 2283. OTHER DEFINITIONS.

''In this title:

''(1) MEDICARE BENEFICIARY; LOW-INCOME MEDICARE BENEFICIARY.—

''(A) The term 'medicare beneficiary' means an individual entitled to benefits under part A of title XVIII.

''(B) The term 'low-income medicare beneficiary' means a medicare beneficiary whose

family adjusted total income (as defined in section 2247(2)), as determined based upon an application under part E, is less than 200 percent of the official poverty line applicable to a family of the size involved.

''(2) OFFICIAL POVERTY LINE.—The term 'official poverty line' means, for an individual in a family, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(3) PREGNANT WOMAN.—The term 'pregnant woman' means a woman who has been certified by a physician (in a manner specified by the Secretary) as being pregnant, until the last day of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

''(4) PUBLIC HEALTH PLAN.—The term 'public health plan' means the program of health insurance provided under this title.

''SEC. 2284. AUTHORIZING RECIPROCAL COVERAGE OF FOREIGN NATIONALS.

''Effective January 1, 1997, the Secretary may make benefits available under this title with respect to required health services for individuals who—

''(1) are not eligible individuals described in section 2201(d),

''(2) are in the United States, and

''(3) are nationals of a foreign state which provides health benefits to nationals of the United States who are in that state,

if the Secretary determines that such benefits with respect to such services would be available to nationals of the United States under comparable circumstances in the foreign state.

''SEC. 2285. NONAPPLICATION TO RESIDENTS OF PUERTO RICO AND TERRITORIES.

''The provisions of this title shall not apply to an individual who is not a resident of one of the 50 States or the District of Columbia.''.

TITLE III—COST CONTAINMENT

Subtitle A—Health Care Spending Amounts

SEC. 301. SPECIFICATION OF OVERALL HEALTH CARE SPENDING AMOUNTS.

(a) AMOUNT.—For purposes of this title, with respect to each year (beginning with 1994), the overall health care spending amount (specified under this section) is the product of—

(1) the average per capita health care expenditures (identified in subsection (c)) in previous year, as estimated by the Secretary, multiplied by the applicable adjustment factor for the year involved specified in subsection (b), and

(2) the population of the United States (excluding medicare beneficiaries), as projected by the Secretary of Commerce as of July 1 of the year involved.

(b) APPLICABLE ADJUSTMENT FACTOR.—The applicable adjustment factor under this subsection for each year is 1 plus the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the gross domestic product (in current dollars, as published by the Secretary of Commerce) during the

3-year period ending with the second previous year; plus

(2)(A) for 1995, 3.5 percentage points,

(B) for 1996, 2.5 percentage points,

(C) for 1997, 1.5 percentage points,

(D) for 1998, 0.5 percentage point, and

(E) for each year thereafter, 0 percentage points.

(c) SERVICES COVERED.—The average per capita health care expenditures shall be based on the expenditures (including expenditures for deductibles and coinsurance) for required and other health services (as defined in subsection (d)) expended in the United States, other than with respect to individuals entitled to benefits under part A or B of title XVIII of the Social Security Act.

(d) REQUIRED AND OTHER HEALTH SERVICES DEFINED.—In this subtitle, the term ''required and other health services'' means required health services, specified in section 2211(a)(2) of the Social Security Act, and also includes prescription drugs, biologicals, and insulin.

SEC. 302. ESTABLISHMENT OF FEDERAL HEALTH CARE COST CONTAINMENT COMMISSION.

(a) IN GENERAL.—There is hereby established a Federal Health Care Cost Containment Commission (in this subtitle referred to as the ''FHCC''). The FHCC shall

be composed of 11 members, appointed by the President by and with the advice and consent of the Senate. The membership of the FHCC shall include individuals with national recognition for their expertise in health economics, health insurance, provider reimbursement, and related fields. In appointing individuals, the President shall assure representation of labor organizations, employers, health care providers, and consumers of health services.

(b) TERMS.—Members of the FHCC shall be appointed to serve for terms of 3 years, except that the terms of the members first appointed shall be staggered so that the terms of no more than 4 members expire in any year. Individuals appointed to fill a vacancy created in the FHCC shall be appointed for the remainder of the term.

(c) DUTIES RELATING TO ESTABLISHMENT OF PAYMENT RATES.—

(1) ALLOCATION OF OVERALL SPENDING BY STATE.—

(A) IN GENERAL.—Each year the FHCC shall apportion the overall health care spending amount specified under section 301 for required and other health services among the States. Subject to subparagraph (B), such apportionment shall be based on the populations of the States, adjusted to reflect differences in age

and health status of the population and the cost-of-living among the States and such other considerations as the FHCC deems appropriate, including such adjustment as will encourage the provision of necessary services in underserved areas.

(B) PHASE-IN.—During the 10-year period beginning in 1994—

(i) initially the apportionment shall reflect the current variations in per capita health care expenditures among the States,

(ii) gradually the apportionment shall reflect to a lesser degree such current variations, and

(iii) at the end of the period the apportionment shall reflect only the factors and considerations described in subparagraph (A).

(2) MONITORING STATE EXPENDITURES.—The FHCC shall monitor the compliance of each State with the overall health care spending amount apportioned under paragraph (1) for each year and over each 3-year period.

(3) APPROVAL OF PAYMENT RATES IN CERTAIN STATES WITHOUT A STATE HEALTH COMMISSION OR

UNABLE TO CONTROL HEALTH CARE EXPENDITURES.—

(A) IN GENERAL.—In the case of a State described in subparagraph (B)—

(i) the FHCC shall conduct negotiations with professional and other associations representing the types of health care providers in order to apportion the overall health care spending apportioned to the States under paragraph (1) among the different classes of providers (as defined in subsection (f));

(ii) the Secretary shall establish, for each class of provider for the year involved and subject to approval by the FHCC under clause (iii), payment rates for required and other health services consistent with the limitation on overall health care spending for such services specified in subparagraph (B)(ii) and reflecting such reduction in payment rates as may be necessary to reduce spending by an amount equal to the amount by which the State has exceeded such spending limitation; and

(iii) the FHCC shall review and, if they meet the standards described in section 304(a), approve the payment rates established by the Secretary under clause (ii) or, if they do not, disapprove such rates.

(B) STATES COVERED.—A State is described in this subparagraph if the FHCC determines that the State—

(i) has failed to establish a State Health Commission in accordance with section 303(a), or

(ii) has permitted over a 3-consecutive-year period overall health care spending for required and other health services in the State to exceed the sum of—

(I) the cumulative overall health care spending amount apportioned to the State under paragraph (1) for that period and

(II) any cumulative difference between a State's overall health care spending for required and other health services in previous periods and spending amounts apportioned to the

State under paragraph (1) for those periods,

until such time as the FHCC determines that such a State Health Commission has been established and that the State has provided the FHCC with satisfactory assurances that overall health care spending for required and other health services in the State will not exceed the overall health care spending amount apportioned to the State under paragraph (1).

(C) PAYMENT BASIS.—The payment rates established under subparagraph (A)(ii) shall be based on payment methodologies (including payment for inpatient hospital services on the basis of per discharge payments relating to diagnosis-related groups and payment for physicians' services based on a resource-based relative value scale) used under title XVIII of the Social Security Act. In establishing such rates, the Secretary shall consult with the Prospective Payment Assessment Commission and with the Physician Payment Review Commission, as appropriate.

(D) APPLICATION OF RATES.—

(i) IN GENERAL.—Except as provided in clause (ii), the rates established under subparagraph (B)(ii) shall be the rate that may be charged by providers under qualified employer health plans or under the public health plan.

(ii) SPECIAL TREATMENT OF PHYSICIANS' SERVICES.—In applying subparagraph (E) in the case of physicians' services, the rate specified under this paragraph shall be the same percentage above the rate otherwise computed under this paragraph as the percentage by which the limiting charge under section 1848(g) of the Social Security Act exceeds the recognized payment amount (as defined in section 1848(g)(2)(D) of such Act).

(E) ENFORCEMENT.—Any health care provider that imposes a charge in excess of the rate specified under this paragraph shall be ineligible for a period (specified by the Secretary) of not more than 5 years to provide services for which payment may be made under title XVIII, XIX, or XXII of the Social Security Act.

(4) APPEALS OF PAYMENT RATES ESTABLISHED BY STATE HEALTH COMMISSIONS.—

(A) PROCESS.—The FHCC shall establish a process for receipt of, and action upon, grievances concerning payment rates established by a State Health Commission under section 303. Such process shall provide for disapproval of such a rate if the rate fails to meet the standards for approval of such a rate under section 304(a).

(B) RATE ADJUSTMENTS.—In the case of such a disapproval, the SHC shall revise rates consistent with such standards.

(d) PERIODIC REPORTS.—The FHCC shall report to the Congress and the public periodically (not less often than annually) on the effect of this title on the delivery of required health care services.

(e) MISCELLANEOUS.—

(1) AUTHORITY.—The FHCC shall have the authority specified in clauses (i) through (vi) of section 1886(e)(6)(C) of the Social Security Act, but (under such clause (i)) not subject to the approval of the Director of the Office.

(2) COMPENSATION.—While serving on the business of the FHCC (including traveltime), a

member of the FHCC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the FHCC. Physicians serving as personnel of the FHCC may be provided a physician comparability allowance by the FHCC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the FHCC in the same manner as it applies to the Tennessee Valley Authority.

(3) ACCESS TO INFORMATION, ETC.—The provisions of subparagraphs (F) and (H) of section 1886(e)(6) of the Social Security Act shall apply to the FHCC in the same manner as they apply to the Prospective Payment Assessment Commission.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from the Public Health Trust Fund (established under section 2233 of the Social Security Act) such sums as may be necessary to carry out this section.

(f) CLASS OF PROVIDER DEFINED.—In this subtitle, the term ''class of provider'' means hospitals, physicians, and such other classes of health care providers (which may include a prepaid system of health care delivery) as the FHCC specifies in regulations.

(g) SECRETARY.—In this subtitle, the term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 303. STATE HEALTH RATE COMMISSIONS.

(a) IN GENERAL.—Each State shall establish a State Health Commission (each in this section referred to as a ''SHC'') to carry out duties under this section. If a State fails to establish such a SHC, the FHCC shall perform functions of such a Commission under section 302(c)(3).

(b) COMPOSITION AND TERMS.—

(1) COMPOSITION.—Each SHC shall be composed of not to exceed 11 members, appointed by the chief executive officer of the State. The membership of each SHC shall include individuals with recognition for their expertise in health economics, health insurance, provider reimbursement, and related fields. In appointing individuals, the chief executive officer shall assure representation of labor organizations, employers, health care providers, and consumers of health services.

(2) TERMS.—Members of each SHC shall be appointed to serve for terms of 3 years, except that the terms of the members first appointed shall be staggered so that the terms of no more than 40 percent of the number of members expire in any year. Individuals appointed to fill a vacancy created in an SHC shall be appointed for the remainder of the term.

(c) DUTIES.—

(1) ALLOCATION OF OVERALL SPENDING BY STATE.—Each year each SHC shall apportion the portion of the health care spending amount apportioned to the State under section 302(c)(1) among required and other health services furnished by the different classes of providers.

(2) ESTABLISHMENT OF PAYMENT RATES.—

(A) IN GENERAL.—Each year each SHC shall establish for each such class of provider payment rates for required and other health services (as defined in section 301(d)) furnished in that State in that year, which meet the standards for approval under section 304(a).

(B) REVISION OF RATES.—If the FHCC determines that particular payment rates do not meet the standard specified under section

304(a)(2) and must be increased to meet such standard, the SHC—

(i) shall increase those payment rates so as to meet such standard, and

(ii) shall provide for such decrease in other payment rates as may be necessary to assure that the standard described in section 304(a)(1) continues to be met (taking into account the increase provided under clause (i)).

(3) USE OF REGIONAL COMMISSIONS IN CARRYING OUT DUTIES.—In carrying out duties of an SHC under this subsection, a State may establish regional commissions to carry out the functions of the SHC on a local basis, within the allocation provided to the region by the SHC.

SEC. 304. STANDARD FOR PAYMENT RATES.

(a) IN GENERAL.—The FHCC shall approve rates established by a State Health Commission (or regional commission) under section 303(c)(2), or the Secretary under section 302(c)(3)(A)(ii), for a class of provider only if the FHCC determines that—

(1) the rates, if applied in the aggregate by all qualified employer health plans and by the public health plan during the year in the State, would re-

sult in total expenditures for required services furnished by that class of provider that are consistent with the amount distributed under section 303(c)(1) or 302(c)(3)(A)(i), as the case may be, for services of that class of provider; and

(2) the rates are reasonable and adequate, consistent with subsection (b).

(b) TEST OF REASONABLENESS AND ADEQUACY.—For purposes of applying subsection (a)(2) with respect to payment rates for required and other health services furnished by a class of provider—

(1) ACCESS AND QUALITY.—Payment rates are not considered to be reasonable and adequate if patients will not have reasonable access to services of high quality.

(2) AGGREGATE ADEQUACY.—The determination of reasonableness and adequacy of payment rates shall be made based on the aggregate rates.

(3) EQUITABLE RATE DISTRIBUTION.—Payment rates are not considered to be reasonable unless they are set equitably among all purchasers without undue discrimination.

(4) APPROPRIATE SETTING.—Payment rates are not considered to be reasonable and adequate unless the rates—

(A) encourage services to be provided to patients in the most cost effective environment that does not endanger patients' well-being, and

(B) include incentives to contain health care costs.

The payment rates may be designed to encourage the provision of necessary services in underserved areas.

SEC. 305. APPLICATION OF RATES UNDER MEDICARE AND PUBLIC PROGRAMS.

Payment rates approved this subtitle shall apply both under the medicare program under title XVIII of the Social Security Act and under the public health plan under title XXII of such Act.

Subtitle B—Administrative Simplification

SEC. 321. REQUIREMENT FOR UNIFORM HEALTH CLAIMS CARDS.

(a) UNIFORM HEALTH CLAIMS CARDS.—

(1) REQUIREMENT.—Each health benefit plan (as defined in section 326(a)) shall issue a health claims card that meets the requirements of subsection (c) for each individual who is entitled to benefits under the plan and who is residing in the United States. Such card shall be issued to the individual involved or, in the case of an individual enrolled as

a dependent of another individual, to that other individual.

(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is 6 months after the date the standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a health benefit plan that fails to issue a health claims card in accordance with subsection (a)(1), the plan is subject to a civil money penalty of not to exceed $100 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EFFECTIVE DATE.—No penalty may be imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

(c) UNIFORM HEALTH CLAIMS CARDS.—

(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting

the form and information to be contained on uniform health claims cards (for purposes of subsection (a)).

(2) ELECTRONIC.—

(A) IN GENERAL.—Subject to subparagraph (B), the card shall be in a form similar to that of a credit card and shall have, encoded in electronic form—

(i) the identity of the individual,

(ii) the health benefit plan in which the individual is enrolled, and

(iii) the telephone number or numbers to be used for the verification electronically of entitlement to benefits under the plan under section 322 and for the submission electronically of claims under the plan under section 323.

(B) USE OF ELECTRONIC READ-AND-WRITE CARDS.—The Secretary may provide for cards in a electronic form that permits information on the card to be readily changed. Such information may include information relating to the health coverage status of the individual and the medical history of the individual.

(C) PERSONAL IDENTIFIER.—For purposes of subparagraph (A) and for purposes of claims processing and related purposes under section 323, the Social Security account number of the individual or, in the case of an infant or other individual to whom such a number has not been issued, such a Social Security account number of a parent or guardian or other number as the Secretary shall specify, shall be used as the personal identifier for the individual.

(3) ADDITIONAL INFORMATION.—The card shall include such additional information, in electronic or other form, as the Secretary may require to carry out the purposes of this Act. In addition, the health benefit plan issuing the card may include such additional information on the card as the plan desires, subject to such limitations as the Secretary may provide.

(4) DEADLINE.—The Secretary shall first establish the standards for uniform health claims cards under this subsection by not later than 12 months after the date of the enactment of this Act.

(d) APPLICATION TO MEDICARE AND MEDICAID PROGRAMS.—

(1) MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out the medicare program, that identification cards issued under that program are modified to the extent required to conform to the standards established under subsection (c), by not later than the deadline specified in subsection (a)(2).

(2) STATE MEDICAID PLANS.—As a condition for the approval of a State plan under the medicaid program, effective for calendar quarters beginning on or after the deadline specified in subsection (a)(2), each such plan shall provide, in accordance with regulations of the Secretary, that identification cards issued under the plan are modified to the extent required to conform to the requirements of subsection (c).

SEC. 322. REQUIREMENT FOR ENTITLEMENT VERIFICATION SYSTEM.

(a) IN GENERAL.—

(1) REQUIREMENT.—Each health benefit plan shall provide for an electronic system, that is certified by the Secretary as meeting the standards established under subsection (c), for the verification of an individual's entitlement to benefits under such plan.

(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is 6 months after the date the standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a health benefit plan that fails to provide for an electronic verification system that is certified by the Secretary as meeting the standards established under subsection (c), the plan is subject to a civil money penalty of not to exceed $100 for each day in which such failure persists. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EFFECTIVE DATE.—No penalty may be imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

(c) STANDARDS FOR ENTITLEMENT VERIFICATION SYSTEMS.—

(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting the requirements for certification of entitlement verification systems.

(2) INFORMATION AVAILABLE.—Such standards shall require a system to provide information, with respect to individuals, concerning the following:

(A) The specific benefits to which the individual is entitled under the plan.

(B) Current status of the individual with respect to fulfillment of deductibles, copayments, and out-of-pocket limits on cost-sharing.

(C) Restrictions on providers who may provide covered services, including utilization controls (such as preadmission certification).

(3) COORDINATION OF BENEFIT INFORMATION.—Such standards shall require a system to provide for the transfer among health benefit plans of appropriate information in determining liability in cases in which benefits may be payable under two or more such plans.

(4) FORM OF INQUIRY.—Each verification system shall be capable of accepting inquiries under this subsection from health care providers (and, to

the extent provided under paragraph (3), from other health benefit plans) in a variety of electronic and other forms, including—

(A) through electronic transmission of information on the uniform health claims card (in a manner similar to that for verification of credit card purchases),

(B) through the use of a touch-tone telephone line, and

(C) through the use of a computer modem.

The system shall also provide, for an additional fee, for the acceptance of inquiries in a nonelectronic form.

(5) FORM OF RESPONSE.—Each such system shall be capable of responding to such inquiries under this subsection in a variety of electronic and other forms, including—

(A) through modem transmission of information,

(B) through computer synthesized voice communication, and

(C) through transmission of information to a facsimile (fax) machine.

The system shall also provide, for an additional fee, for the response to inquiries in a nonelectronic form.

(6) LIMITATION ON FEES.—A health benefit plan may not impose a fee for the acceptance or response to an inquiry under this subsection except where the acceptance or response is in a nonelectronic form.

(7) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health service providers and health benefit plans, such computer software as will enable—

(A) such providers to make inquiries, and receive responses, electronically respecting the eligibility and benefits of an individual under health benefit plans, and

(B) such plans to make inquiries, and receive responses, electronically respecting liability of other plans for the provision or payment of benefits.

(8) DEADLINE.—The Secretary shall first establish the standards under this subsection (and shall develop and make available the software under paragraph (7)) by not later than 12 months after the date of the enactment of this Act.

(d) APPLICATION TO MEDICARE AND MEDICAID PROGRAMS.—

(1) MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out the medicare program, that there is established an entitlement verification system that meets the standards established under subsection (c), by not later than the deadline specified in subsection (a)(2).

(2) STATE MEDICAID PLANS.—As a condition for the approval of a State plan under the medicaid program, effective for calendar quarters beginning on or after the deadline specified in subsection (a)(2), each such plan shall provide, in accordance with regulations of the Secretary, that there is established an entitlement verification system that meets the standards established under subsection (c).

SEC. 323. REQUIREMENTS FOR UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.

(a) REQUIREMENTS.—

(1) SUBMISSION OF CLAIMS.—Each health service provider that furnishes services in the United States for which payment may be made under a health benefit plan shall submit any claim for payment for such services only in a form and manner consistent with standards established under subsection (c).

(2) ACCEPTANCE OF CLAIMS.—A health benefit plan may not reject a claim for payment under the plan on the basis of the form or manner in which the claim is submitted if the claim is submitted in accordance with the standards established under subsection (c).

(3) EFFECTIVE DATE.—This subsection shall apply to claims for services furnished on or after the date that is 6 months after the date standards are established under subsection (c).

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—

(A) PROVIDERS.—In the case of a health service provider that submits a claim in violation of subsection (a)(1), the provider is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

(B) PLANS.—In the case of a health benefit plan that rejects a claim in violation of subsection (a)(2), the plan is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

(2) PROCESS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(3) SUNSET FOR PENALTY.—No civil money penalty may be imposed under this subsection for submission (or rejection) of any claim on or after the date that is 36 months after the effective date specified in subsection (a)(3).

(c) STANDARDS RELATING TO UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.—

(1) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards that—

(A) relate to the form and manner of submission of claims for benefits under a health benefit plan, and

(B) define the data elements to be contained in a uniform electronic claims data set to used with respect to such claims.

(2) SCOPE OF INFORMATION.—

(A) IN GENERAL.—The standards under this subsection are intended to cover substantially most claims that are filed under health

benefit plans. Such information need not include all elements that may potentially be required to be reported under utilization review provisions of plans.

(B) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing such standards, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

(C) COMPONENTS.—In establishing such standards the Secretary shall—

(i) with respect to data elements, define data fields, formats, and medical nomenclature, and plan benefit and insurance information;

(ii) develop a single, uniform coding system for diagnostic and procedure codes; and

(iii) provide for standards for the uniform electronic transmission of such elements.

(3) COORDINATION WITH STANDARDS FOR ELECTRONIC MEDICAL RECORDS.—In establishing standards under this subsection, the Secretary shall assure that—

(A) the development of such standards is coordinated with the development of the standards for electronic medical records under section 324, and

(B) the coding of data elements under the uniform electronic claims data set and the coding of the same elements in the uniform hospital clinical data set are consistent.

(4) USE OF TASK FORCES.—In adopting standards under this subsection—

(A) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute, and

(B) the Secretary shall provide that the electronic transmission standards are consistent, to the extent practicable, with the applicable standards established by the Accredited

Standards Committee X–12 of the American National Standards Institute.

(5) UNIFORM, UNIQUE PROVIDER IDENTIFICATION CODES.—In establishing standards under this subsection—

(A) the Secretary shall provide for a unique identifier code for each health service provider that furnishes services for which a claim may be submitted under a health benefit plan, and

(B) in the case of a provider that has a unique identifier issued for purposes of the medicare program, the code provided under subparagraph (A) shall be the same as such unique identifier.

(6) PUBLIC DOMAIN SOFTWARE TO PROVIDERS.—The Secretary shall provide for the development, and shall make available without charge to health service providers, such computer software as will enable the providers to submit claims and to receive verification of claims status electronically.

(7) STANDARDS FOR PAPER CLAIMS.—The standards shall provide for a uniform paper claims form which is consistent with data elements required for the submission of claims electronically.

(8) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards shall provide that claims for clinical laboratory tests for which benefits are provided under a health benefit plan shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

(9) DEADLINE.—The Secretary shall first provide for the standards for the uniform claims under this subsection (and shall develop and make available the software under paragraph (6)) by not later than 1 year after the date of the enactment of this Act.

(d) USE UNDER MEDICARE AND MEDICAID PROGRAMS.—

(1) REQUIREMENT FOR PROVIDERS.—In the case of a health service provider that submits a claim for services furnished under the medicare program or medicaid program in violation of subsection (a)(1), no payment shall be made under such program for such services.

(2) REQUIREMENTS OF INTERMEDIARIES AND CARRIERS UNDER MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out title XVIII of the Social Security Act, that the claims process provided under that title is modified to the extent required to conform to the standards established under subsection (c).

(3) REQUIREMENTS OF STATE MEDICAID PLANS.—As a condition for the approval of State plans under the medicaid program, effective as of the effective date specified in subsection (a)(3), each such plan shall provide, in accordance with regulations of the Secretary, that the claims process provided under the plan is modified to the extent required to conform to the standards established under subsection (c).

SEC. 324. ELECTRONIC MEDICAL RECORDS AND REPORTING.

(a) STANDARDS FOR ELECTRONIC MEDICAL RECORDS FOR HOSPITALS.—

(1) PROMULGATION OF STANDARDS.—

(A) IN GENERAL.—Between July 1, 1994, and January 1, 1995, the Secretary shall promulgate standards described in paragraph (2)

for hospitals concerning electronic medical records.

(B) REVISION.—The Secretary may from time to time revise the standards promulgated under this paragraph.

(2) CONTENTS OF STANDARDS.—The standards promulgated under paragraph (1) shall include at least the following:

(A) A definition of a uniform hospital clinical data set, including a definition of the set of comprehensive data elements, for use by utilization and quality control peer review organizations.

(B) Standards for an electronic patient care information system with data obtained at the point of care.

(C) A specification of, and manner of presentation of, the individual data elements of the set and system under this paragraph.

(D) Standards concerning the transmission of electronic medical data.

(E) Standards relating to confidentiality of patient-specific information, which include the physical security of electronic data and the use of keys, passwords, encryption, and other

means to ensure the protection of the confidentiality and privacy of electronic data.

(3) COORDINATION WITH STANDARDS FOR UNIFORM ELECTRONIC CLAIMS DATA SET.—In establishing standards under this subsection, the Secretary shall assure that—

(A) the development of such standards is coordinated with the development of the standards for the uniform electronic claims data set under section 323, and

(B) the coding of data elements under the uniform hospital clinical data set and the coding of the same elements under the uniform electronic claims data set are consistent.

(4) CONSULTATION.—in establishing standards under this subsection, the Secretary shall—

(A) consult with the American National Standards Institute, hospitals, health benefit plans, and other interested parties, and

(B) take into consideration, in developing standards under paragraph (2)(A), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

(b) REQUIREMENT FOR APPLICATION OF ELECTRONIC RECORDS STANDARDS TO HOSPITALS.—

(1) AS CONDITION OF MEDICARE PARTICIPATION.—As of January 1, 1996, each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall, in accordance with the standards promulgated under subsection (a)(1)—

(A) maintain clinical data included in the uniform hospital clinical data set under subsection (a)(2)(A) in electronic form on all inpatients,

(B) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically data requested from such data set, and

(C) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set.

(2) APPLICATION OF PRESENTATION AND TRANSMISSION STANDARDS TO ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.—Effective Janu-

ary 1, 1996, if a hospital is required under a Federal program to transmit a data element that is subject to a standard, promulgated under subsection (a)(1), described in subparagraph (C) or (D) of subsection (a)(2), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(c) LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.—

(1) IN GENERAL.—On or after January 1, 1996, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan, that a hospital—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(2) COMPLIANCE.—The Secretary may impose a civil money penalty on any health benefit plan that fails to comply with paragraph (1) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(3) APPLICATION TO MEDICARE PROGRAM.—Effective as of January 1, 1996, neither the Secretary, nor any carrier or fiscal intermediary, nor any utilization and quality control peer review organization may require, for the purpose of utilization review or as a condition of providing benefits or making payments under the medicare program, that a hospital—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or

(B) transmit or present any such data element in a manner inconsistent with such stand-

ards applicable to such transmission or presentation.

(4) APPLICATION TO MEDICAID PROGRAM.—As a condition for the approval of State plans under the medicaid program and in accordance with regulations of the Secretary, effective as of January 1, 1996, each such plan may not require that a hospital, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan—

(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or

(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

(d) PREEMPTION OF STATE QUILL PEN LAWS.—

(1) IN GENERAL.—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form shall be deemed to be satisfied if the records are maintained in an

electronic form that meets standards established by the Secretary under paragraph (2).

(2) SECRETARIAL AUTHORITY.—Not later than 1 year after the the date of the enactment of this Act, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

(3) EFFECTIVE DATE.—Paragraph (1) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in paragraph (2).

SEC. 325. UNIFORM HOSPITAL COST REPORTING.

Each hospital, as a requirement under a participation agreement under section 1866(a) of the Social Security Act for each cost reporting period beginning during or after fiscal year 1993, shall provide for the reporting of

information to the Secretary with respect to any hospital care provided in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form consistent with standards established by Secretary.

SEC. 326. DEFINITIONS.

(a) HEALTH BENEFIT PLAN.—In this subtitle:

(1) IN GENERAL.—The term ''health benefit plan'' means, except as provided in paragraphs (2) through (4), any public or private entity or program that provides for payments for health care services, including—

(A) a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986), and

(B) any other health insurance arrangement, including any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

Such term includes a qualified health plan under title XXI of the Social Security Act, the public

health plan under title XXII of such Act, and the medicare program under title XVIII of such Act.

(2) PLANS EXCLUDED.—Such term does not include—

(A) accident-only, credit, or disability income insurance;

(B) coverage issued as a supplement to liability insurance;

(C) an individual making payment on the individual's own behalf (or on behalf of a relative or other individual) for deductibles, coinsurance, or services not covered under a health benefit plan; and

(D) such other plans as the Secretary may determine, because of the limitation of benefits to a single type or kind of health care, such as dental services, or other reasons should not be subject to the requirements of this section.

(3) PLANS INCLUDED.—Such term includes—

(A) worker's compensation or similar insurance, and

(B) automobile medical-payment insurance.

(4) TREATMENT OF DIRECT FEDERAL PROVISION OF SERVICES.—Such term does not include a

Federal program that provides directly for the provision of health services to beneficiaries.

(b) HEALTH SERVICE PROVIDER.—In this subtitle, the term ''health service provider'' includes a provider of services (as defined in section 1861(u) of the Social Security Act), physician, supplier, and other person furnishing health care services.

(c) SECRETARY.—In this subtitle, the term ''Secretary'' means Secretary of Health and Human Services.

Subtitle C—Malpractice Reform

SEC. 331. MALPRACTICE REFORM.

(a) STUDY BY PHYSICIAN PAYMENT REVIEW COMMISSION.—The Physician Payment Review Commission shall conduct a study of—

(1) the need for reforms with respect to medical malpractice liability claims, including the use of practice guidelines developed by the Agency for Health Care Policy and Research in such reforms, and

(2) the impact of such reforms on—

(A) expenditures for health care services,

(B) access to such services,

(C) the quality of such services, and

(D) access of injured patients to the medical malpractice system.

(b) REPORT.—Not later than March 31, 1994, the Commission shall submit a report to Congress on the study conducted under subsection (a) and shall include in the report such recommendations as the Commission considers appropriate.

TITLE IV—GROUP HEALTH INSURANCE REFORM

SEC. 401. EXCISE TAX ON PREMIUMS RECEIVED ON HEALTH INSURANCE POLICIES WHICH DO NOT MEET CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans), as amended by section 101 of this Act, is further amended by adding at the end thereof the following new section:

"SEC. 5000B. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of any person issuing applicable accident and health insurance contracts, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year the applicable requirements of title XXIII of the Social Security Act. The Secretary of Health and Human Services shall determine whether any contract meets the requirements of such title.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 50 percent of the gross premiums received during such taxable year with respect to all accident and health insurance contracts issued by the person on whom such tax is imposed.

''(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health insurance contract.

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a).

''(d) LIABILITY FOR TAX.—The person issuing the applicable accident and health contract with respect to which a failure occurs shall be liable for the tax imposed by subsection (a).

''(e) DEFINITIONS.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable accident and health insurance contract' means a contract under which a person authorized under applicable State insurance law provides a health insurance plan or arrangement to any group consisting of more than 2 individuals. Such term does not include any self-insured plan of an employer and does not include a qualified health maintenance organization

(as defined in section 1310(d) of the Public Health Service Act).

''(2) CERTAIN CONTRACTS NOT COVERED.—The term 'applicable accident and health insurance contract' does not include any contract—

''(A) which provides for accident only, dental only, or disability only coverage,

''(B) which provides coverage as a supplement to liability insurance,

''(C) which provides insurance arising out of a workmens' compensation or similar law, or automobile medical-payment insurance, or

''(D) which provides insurance which is required by law to be contained under any self-insured plan of an employer.''.

(b) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new item:

''Sec. 5000B. Failure to satisfy certain standards for health insurance.''

SEC. 402. GROUP HEALTH INSURANCE STANDARDS.

The Social Security Act is amended by adding at the end the following new title:

''TITLE XXIII—GROUP HEALTH INSURANCE STANDARDS

''PART 1—GENERAL STANDARDS; DEFINITIONS

"SEC. 2301. APPLICATION OF REQUIREMENTS TO EMPLOYMENT-RELATED HEALTH PLANS.

''(a) APPROVAL BY SECRETARY REQUIRED.—

''(1) IN GENERAL.—No employment-related health plan may be issued on or after the effective date specified in subsection (d) (and no new contract may be offered under such plan with respect to any employer beginning on or after such effective date) unless the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 2302 by such effective date.

''(2) PLAN DISAPPROVED.—If the Secretary determines that an employment-related health plan does not meet the applicable requirements of this title on or after such effective date, no coverage may be provided under the plan to individuals not enrolled as of the date of the determination and the plan may not be continued for plan years beginning after the date of such determination until the Sec-

retary determines that such plan is in compliance with such requirements.

''(b) SANCTIONS.—

''(1) TAX.—For application of excise tax in the case of a nonconforming plan, see section 5000B of the Internal Revenue Code of 1986.

''(2) NOTICE TO EMPLOYER IN THE CASE OF INSURED PLANS.—If tax is imposed under section 5000B of the Internal Revenue Code of 1986, the Secretary of the Treasury shall provide for notice to be provided to each employer which meets the requirement of section 2101 through coverage under the plan of the imposition of the tax.

''(3) LOSS OF STATUS AS QUALIFIED EMPLOYER HEALTH PLAN.—

''(A) IN GENERAL.—If an employment-related health plan is determined to be in violation of subsection (a) and is not determined to have come into compliance with the applicable standards within 6 months after the date of the initial determination of such a violation, the plan shall no longer be treated as a qualified employer health plan under title XXI as of the end of such 6-month period.

''(B) NO ENFORCEMENT OF INSURANCE CONTRACTS.—In the case of an employer that is required, under part A of title XXI, to provide enrollment under a qualified employer health plan and that meets such requirement through an insured plan that is determined to be in violation of subsection (a)—

''(i) if such plan is not brought into compliance within 30 days after the date of the violation, the employer may terminate by notice the contract with the plan and is not liable for payment of any additional amounts under the plan, and

''(ii) if such plan no longer qualifies as a qualified employer health plan, such contract shall be terminated and the employer is not liable for payment of any amounts for periods in which the plan no longer qualifies as a qualified employer health plan.

''(d) EFFECTIVE DATE.—The effective date specified in this subsection is January 1, 1994.

"SEC. 2302. ESTABLISHMENT OF STANDARDS.

''(a) ESTABLISHMENT OF STANDARDS.—The Secretary shall develop and publish, by not later than October

1, 1993, specific standards to implement the requirements of this title and to be applied under section 5000B of the Internal Revenue Code of 1986.

''(b) TELEPHONE INFORMATION SYSTEM.—The Secretary shall provide for the establishment of a toll-free telephone information and complaint system which provides for—

''(1) a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health plans with the requirements of this title, and

''(2) information to small employers about carriers that offer small employer health plans in the area covered by the regulatory authority.

Such system shall provide for the recording of consumer complaints in accordance with a uniform methodology recognized by the Secretary.

''(c) APPLICATION TO ERISA.—The Secretary shall consult with the Secretary of Labor concerning the application of the requirements of this part to employee welfare benefit plans under title I of the Employee Retirement Income Security Act of 1974.

''SEC. 2303. REQUIREMENTS APPLICABLE TO ALL EMPLOYMENT-RELATED HEALTH PLANS.

''(a) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—Except as provided under subsection (b), an employment-related health plan may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to required health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(b) TREATMENT OF PRE-EXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—The provisions of section 2154(b) (relating to treatment of pre-existing condition exclusion) shall apply to employer-related health plans under this section in the same manner as they apply to qualified health plans under that section.

''SEC. 2304. DEFINITIONS.

''(a) HEALTH PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—In this title:

''(1) HEALTH PLAN.—

''(A) IN GENERAL.—The term 'health plan' means—

''(i) a group health plan (as defined in section 605 of the Employee Retirement Income Security Act of 1974), and

''(ii) any other health insurance arrangement, including any arrangement (other than a group health plan) consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance organization subscriber contract;

but does not include a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

''(B) EXCLUSIONS.—

''(i) CERTAIN TYPES OF INSURANCE.—Such term does not include—

''(I) accident-only, credit, or disability income insurance,

''(II) coverage issued as a supplement to liability insurance,

''(III) worker's compensation or similar insurance, or

''(IV) automobile medical-payment insurance.

''(ii) PUBLIC HEALTH PLAN.—Such term does not include the public health plan under title XXII.

''(2) EMPLOYMENT-RELATED HEALTH PLAN.—The term 'employment-related health plan' means any employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) that is a health plan.

''(3) INSURED EMPLOYMENT-RELATED HEALTH PLAN.—The term 'insured employment-related health plan' means an employment-related health plan that has been provided by a person authorized under applicable State insurance law, and does not include any self-insured employment-related health plan.

''(4) SELF-INSURED EMPLOYMENT-RELATED HEALTH PLAN.—The term 'self-insured employment-related health plan' means an employment-related health plan in which the employer or employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

''(5) SMALL EMPLOYER HEALTH PLAN.—The term 'small employer health plan' means an employment-related health plan insofar as it offers benefits with respect to any small employer, as defined in

subsection (c)(4), or the employees of a small employer.

''(b) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—In this part:

''(1) CARRIER.—The term 'carrier' means any person that offers a health plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, and a multiple employer welfare arrangement.

''(2) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b).

''(3) SELF-INSURER CARRIER.—The term 'self-insurer carrier' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health plan directly with respect to an employment-related group.

''(4) SMALL EMPLOYER CARRIER.—The term 'small employer carrier' means any carrier which offers small employer health plans.

''(c) GENERAL DEFINITIONS.—In this part:

''(1) COMMUNITY.—The term 'community' has the meaning given such term in section 2131(e).

''(2) FULL-TIME EMPLOYEE.—The term 'full-time employee' has the meaning given such term in section 2181(b)(1).

''(3) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for a rating period in a community, the lowest premium rate charged or which could have been charged by the small employer carrier to small employers under a rating system in the community for health plans with the same or similar coverage. The reference premium rate is determined without regard to any adjustment for age or sex described in section 2312(c).

''(4) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term in section 2181(c)(1) and also includes a medium-size employer (as defined in section 2181(c)(2)).

''(5) STATE.—The term 'State' means the 50 States and the District of Columbia.

"SEC. 2305. NOTICE OF PLANS MEETINGS REQUIREMENTS.

''The Secretary of Health and Human Services shall publish periodically the names and issuers of insured employment-related small employer health plans that have

been found to meet the applicable requirements of this title.

''PART 2—SMALL EMPLOYER HEALTH INSURANCE REFORM

"SEC. 2311. ENROLLMENT PRACTICE AND GUARANTEED RENEWABILITY REQUIREMENTS FOR SMALL EMPLOYER HEALTH PLANS.

''(a) REGISTRATION.—

''(1) IN GENERAL.—Each small employer carrier (as defined in section 2304(b)(5)) shall register with the Secretary.

''(2) NO PREEMPTION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority in a State from requiring, in the case of carriers that are not self-insurance carriers, such additional information in conjunction with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

''(b) GUARANTEED ISSUE.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier that offers a health plan to small employers located in a community must offer the same plan to any other small

employer located in the community. Such requirement shall apply on a continuous, year-round basis.

''(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

''(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny enrollment to employees (and family members) of a small employer if the employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

''(B) SIZE LIMITS.—A health maintenance organization may apply to the Secretary to cease enrolling new small employer groups in its small employer health plan (or in a geographic area served by the plan) if—

''(i) it ceases to enroll any new employer groups, and

''(ii) it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be im-

paired if it is required to enroll new employer groups.

''(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—A carrier may refuse to issue or renew or terminate a plan only for—

''(A) nonpayment of premiums, and

''(B) fraud or misrepresentation.

''(c) MINIMUM PLAN PERIOD.—A carrier may not offer to, or issue with respect to, a small employer a small employer health plan with a term of less than 12 months.

''(d) NOTICES AND RENEWAL PERIODS.—

''(1) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

''(A) NOTICE.—The small employer carrier of a small employer health plan shall provide for notice, at least 30 days before the date of expiration of the health plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

''(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged

with respect to such renewal shall be the same as that for a new issue.

''(2) PERIOD OF RENEWAL.—The period of renewal of each small employer health plan shall be for a period of not less than 12 months.

"SEC. 2312. RATING PRACTICES FOR SMALL EMPLOYER HEALTH PLANS.

''(a) COHESIVE RATING SYSTEM AND ACTUARIAL CERTIFICATION.—

''(1) IN GENERAL.—The premiums (including reference premium rate, as defined in section 2304(c)(3)) and age-sex adjustments under subsection (c) for all small employer health plans of the same entity shall—

''(A) be established based on a single cohesive rating system which is applied consistently for all employer groups and is designed not to treat groups, after January 1, 1994, differently based on health status or risk status; and

''(B) be actuarially certified annually.

''(2) ACTUARIAL CERTIFIED DEFINED.—For purposes of paragraph (1)(B), a plan is considered to be 'actuarially certified' if there is a written statement, by a member of the American Academy of Actuaries or other individual acceptable to the Sec-

retary that a small employer carrier is in compliance with this section, based upon the individual's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health plans.

''(b) USE OF COMMUNITY-RATED REFERENCE PREMIUM RATES.—The reference premium rate charged for a small employer health plan with similar benefits in a community for a type of family enrollment (described in subsection (d)) shall be the same for all small employers.

''(c) AGE AND SEX ADJUSTMENT TO COMMUNITY-RATING.—

''(1) IN GENERAL.—Subject to paragraph (2), a small employer health plan may provide for an adjustment to the reference premium rate based on age and gender of covered individuals. Any such adjustment shall be applied consistently to all small employers.

''(2) LIMITATION ON ADJUSTMENT.—The adjustment under paragraph (1) may not result, with respect to small employer health plans with similar benefits in a community, in a premium rate for the most expensive age-sex group exceeding 133 percent

of the premium rate for the least expensive age-sex group.

''(d) TYPES OF FAMILY ENROLLMENT.—

''(1) IN GENERAL.—Each small employer health plan shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

''(A) 1 adult.

''(B) A married couple without children.

''(C) A married couple with 1 or more children, or 1 adult with 1 or more children.

''(2) APPLICATION OF DEFINITIONS.—The definitions in section 2282 shall apply for purposes of this subsection.

"SEC. 2313. BASIC BENEFIT PACKAGE FOR SMALL EMPLOYER HEALTH PLANS.

''(a) BENEFITS AND COST-SHARING IN QUALIFIED EMPLOYER HEALTH PLANS.—Except as provided in subsection (b), no small employer health plan may be issued to a small employer by a carrier unless—

''(1) the plan provides for benefits for all required health services (as defined in section 2211(a)(2));

''(2) the plan does not impose cost-sharing with respect to required health services in excess of the

deductibles and coinsurance permitted under title XXII with respect to such services (not taking into account any low-income assistance under part E of such title); and

''(3) the carrier makes available to the employer a small employer health plan that, subject to subsection (b), only provides the benefits for required health services and the maximum cost-sharing consistent with paragraphs (1) and (2).

''(b) EXCEPTIONS FOR HMO'S.—Subsection (a)(3) shall not apply to the plan of a health maintenance organization.

"SEC. 2314. MISCELLANEOUS DISCLOSURE AND RECORDKEEPING REQUIREMENTS FOR SMALL EMPLOYER HEALTH PLANS.

''(a) DISCLOSURE TO EMPLOYERS.—

''(1) GENERAL DISCLOSURE.—Each small employer carrier shall disclose to each small employer before issuing a small employer health plan the following:

''(A) The availability (pursuant to the requirement of section 2313(a)(3) of a plan including only basic benefits.

''(B) The limits, imposed under section 2312, on the premiums permitted to be charged for such plans.

''(C) The rights of guaranteed issue provided under section 2311.

Such disclosure shall be in addition to any disclosure required generally of qualified health plans under section 2158(a).

''(2) STANDARD FORMAT.—The disclosure under paragraph (1) shall be made in a uniform format established by the Secretary.

''(b) INFORMATION FILED.—

''(1) IN GENERAL.—Each small employer carrier shall disclose to the Secretary, in a manner specified by the Secretary, information concerning applicable premiums for small employer health plans.

''(2) ADDITIONAL INFORMATION.—Nothing in this subsection shall be construed as limiting the information which a State may require to be reported by small employer carriers (other than self-insured carriers).

''SEC. 2315. PAYMENT OF COMMISSIONS.

''A small employer carrier may not vary the remuneration paid a broker for the sale or renewal of any small

employer health plan based, directly or indirectly, on the claims experience associated with the group to which the plan was sold.

''SEC. 2316. NONAPPLICATION IN PUERTO RICO AND THE TERRITORIES.

''This part shall not apply outside the 50 States or the District of Columbia.''.

TITLE V—CHANGES IN MEDICARE PROGRAM

SEC. 501. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4163(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (in this title referred to as ''OBRA–1990''), is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS AND SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

''(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to screening fecal-occult blood tests provided for the purpose of early detection of colon cancer,

except as provided by the Secretary under paragraph (3)(A), the payment amount established for tests performed—

''(i) in 1994 shall not exceed $5; and

''(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer—

''(i) if the individual is under 50 years of age; or

''(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section

1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer—

''(i) if the individual is under 50 years of age; or

''(ii) if the procedure is performed within the 59 months after a previous screening flexible sigmoidoscopy.

''(3) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

''(A) REDUCTIONS IN PAYMENT LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Sec-

retary may, with respect to tests performed in a year after 1996, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

''(B) REVISION OF FREQUENCY.—

''(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening fecal-occult blood tests and screening flexible sigmoidoscopies based on age and such other factors as the Secretary believes to be pertinent.

''(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such revision shall apply to tests or procedures performed before January 1, 1997.

''(4) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

''(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if less, as defined in section 1848(g)(2)).

''(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, 115 percent of the payment limit established under paragraph (2)(A).

''(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).''.

(b) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) of such Act (42 U.S.C. 1395l(a)) are each amended by striking ''sub-

section (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(2) Section 1833(h)(1)(A) of such Act (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to paragraphs (1) and (3)(A) of section 1834(d), the Secretary''.

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) of such Act (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking ''a service'' and inserting ''a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer)''.

(4) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

(iii) by adding at the end the following new subparagraph:

''(G) in the case of screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer,

which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to screening fecal-occult blood tests and screening flexible sigmoidoscopies performed on or after January 1, 1994.

SEC. 502. COVERAGE OF CERTAIN IMMUNIZATIONS.

(a) IN GENERAL.—Section 1861(s)(10) of the Social Security Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) in subparagraph (A)—

(A) by striking '', subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,'', and

(B) by striking ''; and'' and inserting a comma;

(2) in subparagraph (B), by striking the semicolon at the end and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(C) tetanus-diphtheria booster and its administration;''.

(b) LIMITATION ON FREQUENCY.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by section 502(b)(4)(A), is amended—

(1) in subparagraph (F), by striking ''and'' at the end;

(2) in subparagraph (G), by striking the semicolon at the end and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(H) in the case of an influenza vaccine, which is administered within the 11 months after a previous influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within the 119 months after a previous tetanus-diphtheria booster;''.

(c) CONFORMING AMENDMENT.—Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 502(b)(4)(B), is amended by striking ''or (G)'' and inserting ''(G), or (H)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to influenza vaccines and tetanus-diphtheria boosters administered on or after January 1, 1994.

SEC. 503. COVERAGE OF WELL-CHILD CARE.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 4201(d)(1) of OBRA–1990, is amended—

(1) by striking ''and'' at the end of subparagraph (O);

(2) by striking the semicolon at the end of subparagraph (P) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(Q) well-child services (as defined in subsection (ll)(1)) provided to an individual entitled to benefits under this title who is under 19 years of age;''.

(b) SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) added by section 4163(a)(2) of OBRA–1990 as subsection (kk); and

(2) by inserting after subsection (kk) (as so redesignated) the following new subsection:

''well-child services

''(ll)(1) The term 'well-child services' means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care, provided in accordance

with the periodicity schedule established with respect to the services under paragraph (2).

''(2) The Secretary, in consultation with the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided to healthy children.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by sections 502(b)(4)(A) and 503(b), is amended—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in subparagraph (H), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(I) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(ll)(2) for such services;''.

(2) Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by sections 502(b)(4)(B) and

503(c), is amended by striking ''or (H)'' and inserting ''(H), or (I)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to well-child services provided on or after January 1, 1994.

SEC. 504. ANNUAL SCREENING MAMMOGRAPHY.

(a) ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the Social Security Act (42 U.S.C. 1395m(b)(2)(A)), as added by section 4163(b)(2) of OBRA–1990, is amended—

(1) in clause (iv), by striking ''but under 65 years of age,''; and

(2) by striking clause (v).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to screening mammography performed on or after January 1, 1994.

SEC. 505. DEMONSTRATION PROJECTS FOR COVERAGE OF OTHER PREVENTIVE SERVICES.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall establish and provide for the conduct of a series of ongoing demonstration projects under which the Secretary shall provide for coverage of the preventive services described in subsection (c) under the medicare program in order to determine—

(1) the feasibility and desirability of expanding coverage of medical and other health services under the medicare program to include coverage of such services for all individuals enrolled under part B of title XVIII of the Social Security Act; and

(2) appropriate methods for the delivery of those services to medicare beneficiaries.

(b) SITES FOR PROJECT.—The Secretary shall provide for the conduct of the demonstration projects established under subsection (a) at the sites at which the Secretary conducts the demonstration program established under section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and at such other sites as the Secretary considers appropriate.

(c) SERVICES COVERED UNDER PROJECTS.—The Secretary shall cover the following services under the series of demonstration projects established under subsection (a):

(1) Glaucoma screening.

(2) Cholesterol screening and cholesterol-reducing drug therapies.

(3) Screening and treatment for osteoporosis, including tests for bone-marrow density and hormone replacement therapy.

(4) Screening services for pregnant women, including ultra-sound and clamydial testing and maternal serum alfa-protein.

(5) One-time comprehensive assessment for individuals beginning at age 65 or 75.

(6) Other services considered appropriate by the Secretary.

(d) REPORTS TO CONGRESS.—Not later than October 1, 1995, and every 2 years thereafter, the Secretary shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives describing findings made under the demonstration projects conducted pursuant to subsection (a) during the preceding 2-year period and the Secretary's plans for the demonstration projects during the succeeding 2-year period.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Supplementary Medical Insurance Trust Fund for expenses incurred in carrying out the series of demonstration projects established under subsection (a) the following amounts:

(1) $4,000,000 for fiscal year 1994.

(2) $4,000,000 for fiscal year 1995.

(3) $5,000,000 for fiscal year 1996.

(4) $5,000,000 for fiscal year 1997.

(5) $6,000,000 for fiscal year 1998.

SEC. 506. OTA STUDY OF PROCESS FOR REVIEW OF MEDICARE COVERAGE OF PREVENTIVE SERVICES.

(a) STUDY.—The Director of the Office of Technology Assessment (in this section referred to as the ''Director'') shall, subject to the approval of the Technology Assessment Board, conduct a study to develop a process for the regular review for the consideration of coverage of preventive services under the medicare program, and shall include in such study a consideration of different types of evaluations, the use of demonstration projects to obtain data and experience, and the types of measures, outcomes, and criteria that should be used in making coverage decisions.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Director shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on the study conducted under subsection (a).

SEC. 507. PHASED-IN REQUIREMENT OF PART B ENROLLMENT.

(a) IN GENERAL.—Section 1811 of the Social Security Act (42 U.S.C. 1395c) is amended by inserting ''(a)'' after ''1811.'' and by adding at the end the following new subsection:

''(b) Notwithstanding sections 226 and 226A and any other provision of this title, effective for services furnished on or after January 1, 1997, payment may not be made under this part for items and services during any period in which the individual is not enrolled under part B or under a qualified employer health plan (as defined in section 2121(a)). For purposes of the previous sentence, entitlement to benefits under this part (but for this subsection) shall not be considered enrollment in a qualified health plan.''.

(b) CLARIFICATION OF COVERAGE PERIOD.—Section 1838(b) of such Act (42 U.S.C. 1395q(b)) is amended to read as follows:

''(b)(1) An individual's coverage period shall continue until the individual's enrollment is terminated by the filing of notice that the individual—

''(A) no longer wishes to participate in the insurance program established by this part,

''(B) is covered under a qualified health plan, and

''(C) has notified the plan that the individual is entitled to benefits under part A of this title.

''(2) The termination of coverage under paragraph (1) shall take effect at the close of the month following the month in which the notice is filed.

''(3) Such termination shall no longer be effective at such time as the individual is eligible to be enrolled under this part and is no longer covered under a qualified health plan.''.

(c) ELIMINATION OF LATE ENROLLMENT PENALTIES.—

(1) IN GENERAL.—Section 1839 of such Act (42 U.S.C. 1395r) is amended by striking subsection (b).

(2) CONFORMING AMENDMENTS.—(A) Section 1839(a)(2) of such Act (42 U.S.C. 1395r(a)(2)) is amended—

(i) in subsection (a)(2), by striking ''subsections (b) and (e)'' and inserting ''subsection (e)'', and

(ii) by striking subsection (d).

(B) Section 1843(d)(1) of such Act (42 U.S.C. 1395v(d)(1)) is amended by striking ''(without any increase under subsection (b) thereof)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (b) and (c) shall take effect January 1, 1997, and shall apply to premiums beginning with such January.

SEC. 508. CHANGES IN PARTICIPATION AGREEMENTS.

(a) PROVIDERS OF SERVICES.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (P),

(2) by striking the period at the end of subparagraph (Q) and inserting '', and'', and

(3) by inserting after subparagraph (Q) the following new subparagraph:

''(R) effective January 1, 1994, to have entered into a participation agreement under title XXII of this Act and to report to the Federal Health Care Cost Containment Commission information, described in section 302(d)(2) of the Health Insurance Coverage and Cost Containment Act of 1993, in accordance with uniform standards developed under such section.''.

(b) PHYSICIANS.—Section 1842(h)(1) of such Act (42 U.S.C. 1395u(h)(1)) is amended by adding at the end the following: ''No such agreement with a physician shall be entered into and continued in effect on or after January

1, 1994, unless the physician has entered into a comparable agreement for purposes of title XXII and agrees to report to the Federal Health Care Cost Containment Commission information, described in section 302(d)(2) of the Health Insurance Coverage and Cost Containment Act of 1993, in accordance with uniform standards developed under such section.''

SEC. 509. ASSURING COORDINATION OF ENROLLMENT WITH QUALIFIED HEALTH PLANS.

(a) NOTICES.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(j) The Secretary shall provide for notices of coverage under this part (and part A) in the same manner as qualified health plans are required to provide notices of coverage under section 2157(b).''.

(b) TREATMENT OF SECONDARY PAYMENT IN CASE OF PART-TIME EMPLOYMENT.—Section 1862(b)(1)(A)(i)(I) of such Act (42 U.S.C. 1395y(b)(1)(A)(i)(I)) is amended by inserting ''other than on a part-time described in section 2181(b)(2)'' after ''individual's spouse)''.

(c) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall take effect on the date specified in section 2157(b)(2) of the Social Security Act.

(2) The amendment made by subsection (b) shall apply to employment occurring on or after January 1, 1994.

TITLE VI—FINANCING PROVISIONS

Subtitle A—General Provisions

SEC. 601. INCREASE IN WAGE BASE FOR HOSPITAL INSURANCE TAX.

(a) GENERAL RULE.—Paragraph (2) of section 3121(x) of the Internal Revenue Code of 1986 (defining applicable contribution base for hospital insurance tax) is amended—

(1) in subparagraph (A), by striking ''and'' at the end,

(2) in subparagraph (B), by striking ''for any calendar year after 1991'' and inserting ''for calendar years 1992 and 1993'' and by striking the period at the end and inserting '', and'', and

(3) by adding at the end the following new subparagraph:

''(C) for any calendar year after 1993, an amount without any limit.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to calendar year 1994 and following calendar years.

Subtitle B—Deductibility of Certain Health Insurance Costs

SEC. 611. INDEFINITE EXTENSION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

SEC. 612. INCREASE IN AMOUNT OF DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) GENERAL RULE.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended by striking ''25 percent of''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1993.

(2) SPECIAL RULES FOR SELF-EMPLOYED INDIVIDUALS AND PERSONAL CORPORATIONS BEFORE ''PAY-OR-PLAY PROVISIONS'' TAKE EFFECT.—

(A) IN GENERAL.—If the requirements of subparagraph (B) are not met by any taxpayer to whom this paragraph applies during any period before the ''pay-or-play'' provisions take effect with respect to such taxpayer—

(i) in the case of a taxpayer described in subparagraph (C)(i), the amount allowable as a deduction to such taxpayer under section 162(l) of the Internal Revenue Code of 1986 for amounts attributable to such period shall be determined without regard to the amendment made by subsection (a), and

(ii) in the case of a taxpayer described in subparagraph (C)(ii), the amount allowable as a deduction under such Code for amounts which are attributable to such period and which are paid or incurred for coverage provided to any employee-owner under an accident or health plan of such taxpayer shall be 25 percent of the amount which but for this clause would have been so allowable.

For purposes of clause (ii), the term ''owner-employee'' has the meaning given such term by

section 269A(b)(2) of such Code with the modifications provided in section 441(i)(2) of such Code.

(B) REQUIREMENTS.—The requirements of this subparagraph are met by any taxpayer for any period if such taxpayer makes available on the same terms and conditions health coverage under a plan which would qualify as a qualified employer health plan under title XXI of the Social Security Act to all employees of such taxpayer who normally work for 17½ hours or more per week.

(C) TAXPAYERS TO WHOM PARAGRAPH APPLIES.—This paragraph shall apply to—

(i) any individual who is an employee within the meaning of section 401(c)(1) of such Code, and

(ii) any personal service corporation (as defined in section 441(i)(2) of such Code).

(D) WHEN ''PAY-OR-PLAY'' PROVISIONS TAKE EFFECT.—For purposes of this paragraph, the ''pay-or-play'' provisions take effect on January 1, 1997, or, if earlier, the date on which the requirements of part A of title XXI

of the Social Security Act apply with respect to the taxpayer under section 2105(a) of such Act.

SEC. 613. DEDUCTION FOR PREMIUMS PAID BY SMALL EMPLOYERS FOR INSURANCE PROVIDING QUALIFIED HEALTH COVERAGE.

(a) IN GENERAL.—Part VI of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to itemized deductions for individuals and corporations) is amended by adding at the end thereof the following new section:

"SEC. 197. PREMIUMS PAID BY SMALL EMPLOYERS FOR INSURANCE PROVIDING QUALIFIED HEALTH COVERAGE.

''(a) IN GENERAL.—In the case of a small employer, there shall be allowed as a deduction (in addition to any amount otherwise allowable) an amount equal to 20 percent of the premiums paid during the taxable year for insurance providing coverage under a qualified health plan for employees of such employer.

''(b) SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'small employer' means, with respect to the taxable year, an employer that normally employs fewer than 100 employees on

a typical business day during the calendar year ending with or within such taxable year.

''(2) CONTROLLED GROUPS.—All employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer.

''(c) QUALIFIED HEALTH PLAN.—For purposes of this section, the term 'qualified health plan' means any plan which meets the requirements of title XXI of the Social Security Act and which provides only the minimum benefits required under such title.''

(b) CLERICAL AMENDMENT.—The table of sections for part IV of subchapter B of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Sec. 197. Premiums paid by small employers for insurance providing qualified health coverage.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to premiums for coverage provided after December 31, 1996.

Subtitle C—State Maintenance of Effort

SEC. 621. STATE MAINTENANCE OF EFFORT.

(a) CONDITION OF COVERAGE.—Notwithstanding any other provision of this title, no individual who is a resident of a State is eligible for benefits under title XXII

for a month in a calendar year beginning with 1997, unless the State provides (in a manner and at a time specified by the Secretary) for payment to the Public Health Trust Fund of 1/12 of the amount specified in subsection (b) for the year.

(b) MAINTENANCE OF EFFORT AMOUNT.—The amount of payment specified in this subsection for a State for a year is equal to the difference between—

(1) the amount of payment (net of Federal payments) that would have been made, for required health benefits (as defined in section 2211(a)(2) of the Social Security Act), under its State plan under title XIX of such Act for the year if—

(A) title XXII of such Act were not in effect in the year, and

(B) the provisions of section 702(a) of this Act (and section 1902(a)(13)(G) of the Social Security Act, as added by section 702(b)) applied during the year as in 1996 (except that in applying such provisions the references in section 702(a)(1)(A)(iii) of this Act and section 1902(a)(13)(G)(ii)(III) of the Social Security Act to ''90 percent'' are deemed references to ''100 percent''), and

(2) the amount of payment (net of Federal payments) that is made, for required health benefits (as defined in section 2211(a)(2) of the Social Security Act), under its State plan under title XIX of the Social Security Act for the year.

(c) STATE DEFINED.—In this section, the term ''State'' means the 50 States and the District of Columbia.

TITLE VII—MEDICAID PROVISIONS

SEC. 701. COORDINATION WITH PUBLIC HEALTH PLAN.

(a) IN GENERAL.—

(1) LIMITING FEDERAL FINANCIAL PARTICIPATION FOR SERVICES COVERED UNDER PUBLIC HEALTH PLAN.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(A) in the paragraph (10) inserted by section 4401(a)(1)(B) of Omnibus Budget Reconciliation Act of 1990, by striking all that follows ''1927(g)'' and inserting a semicolon;

(B) by redesignating the paragraph (10) added by section 4701(b)(2) as paragraph (11), by transferring and inserting it after the paragraph (10) inserted by section 4401(a)(1)(B) of Omnibus Budget Reconciliation Act of 1990,

and by striking all that follows ''with respect to hospitals or facilities'' and inserting a semicolon;

(C) by transferring and inserting the paragraph (12) inserted by section 4752(a)(2) of Omnibus Budget Reconciliation Act of 1990 after paragraph (11), as redesignated by subparagraph (B), and by striking the period at the end and inserting a semicolon;

(D) by redesignating the paragraph (14) inserted by section 4752(e) of Omnibus Budget Reconciliation Act of 1990 as paragraph (13), by transferring and inserting it after paragraph (12), and by striking the period at the end and inserting a semicolon;

(E) by redesignating the paragraph (11) inserted by section 4801(e)(16)(A) of Omnibus Budget Reconciliation Act of 1990 as paragraph (14), by transferring and inserting it after paragraph (13), and by striking the period at the end and inserting ''; or''; and

(F) by inserting after paragraph (14), as so redesignated, the following new paragraph:

''(15) with respect to items and services (including medicare cost-sharing) for which payment is

made under the public health plan under title XXII.''.

(2) CLARIFICATION OF NONDUPLICATION OF MEDICAL ASSISTANCE WITH BENEFITS UNDER PUBLIC HEALTH PLAN.—Title XIX of such Act is amended by adding at the end the following new section:

''NONDUPLICATION OF BENEFITS WITH PUBLIC HEALTH PLAN

''SEC. 1931. Notwithstanding any other provision of this title, a State is not required under its plan under section 1901(a) to provide medical assistance for items and services (including medicare cost-sharing) for which payment is made under the public health plan under title XXII.''.

(3) CLARIFICATION OF APPLICATION OF THIRD-PARTY PAYOR RULES TO QUALIFIED HEALTH PLANS.—Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)) is amended by inserting ''and qualified health plans certified under part F of title XXII'' after ''health insurers''.

(b) CONTINUATION OF MEDICAID BENEFITS NOT COVERED UNDER PUBLIC HEALTH PLAN.—Nothing in this Act shall be construed as—

(1) changing the eligibility of individuals for medical assistance under title XIX of the Social Security Act, or

(2) subject to the amendments made by subsection (a), changing the amount, duration, or scope of medical assistance required (or permitted) to be provided under such title.

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